Mental Health Medication Advisory Committee Meeting Meeting Minutes, Open Session May 10, 2016 at 2 pm – 4 pm		
MHMAC Meeting Minutes Open Session HP Enterprise Services Capital Room 6511 SE Forbes Ave, Topeka, KS 66619	**Members Present:** Aaron Dunkel, Deputy Secretary of KDHE/ Appointed Temporary MHMAC Chair Vishal Adma, MD, MS, CMQ, CPE Holly Cobb, NP Nicole Ellermeier, PharmD Charles Millhuff, DO Taylor Porter, MD **Members Absent:** Susan Mosier, Secretary of KDHE, MD, MBA, FACS (Chair) Karen Moeller, PharmD, BCPP Rebecca Klingler, MD Brad Grinage, MD **KDHE Staff Present:** Liane Larson, PharmD, MPH, KDHE/DHCF Monica Cuba, KDHE Carol Arace, KDHE/DHCF **MCO Representatives Present:** Jennifer Murff, RPh – United Healthcare John Esslinger, MD, MMM – United Healthcare Sosunmolu Shoyinka, MD – Sunflower Jonalan Smith, MD – Sunflower William Mack, MD – Amerigroup Lisa Todd, RPh, BBA – Amerigroup **HP Staff Present:** Nancy Perry, RN	**Representatives:** Susan Zalenski, J&J; Mitchell DePriest, HGI; Chris Beal, Otsuka; Kyle Kessler, ACMHC; Amy ?, KMHC

	DISCUSSION	DECISION AND/OR ACTION
I. Call to Order A. Introductions B. Announcements	**Call to Order:** 2:05pm Dep. Sec. Dunkel: Alright. We have quorum in seats, so we can get started. We'll go ahead and do introductions around the table real quick. Then we'll hit folks that are here in the gallery. Carol, if you'll start, we'll work around the table. **Introductions:** Ms. Arace: Carol Arace. Administrative Assistant with KDHE, Division of Health Care Finance. Dr. Larson: Liane Larson. I'm a Pharmacist at KDHE. Dr. Millhuff: Hi. Chip Millhuff. I'm a Child Psychiatrist at Family Service and Guidance Center, Mental Health Center here in Topeka. Dr. Ellermeier: Nicole Ellermeier. I'm a Pharmacist with Med Trak. Dr. Porter: Hi. Ty Porter. I'm a Psychiatrist and Interim Medical Director and Valeo Behavioral Health. Dep. Sec. Dunkel: Aaron Dunkel. Deputy Secretary of Kansas Department of Health and Environment. Ms. Cobb: Holly Cobb, Family Nurse Practitioner with Oasis Family Medicine private practice. Dr. Adma: Vishal Adma, past President for Kansas Psychiatric Society and Medical Director for KVC Hospitals. Dr. Todd: Lisa Todd with Amerigroup; Pharmacist. Dr. Smith: Jonalan Smith, Pharmacist with Sunflower Health Plan. Dr. Murff: Jennifer Murff a Pharmacist with United Healthcare. Dr. Esslinger will be here momentarily. Gallery: Ms. Perry: Nancy Perry. Nurse with Pharmacy here at HP. Ms. Stalcup: I'm Megan. I'm a Policy Analyst here at HP.	

	Ms. Cuba: Monica Cuba. I'm a Data Analyst at KDHE. Mr. DePriest: Mitchell DePriest, Governmental Affairs Consultant with Hein. Ms. Zalenski: Hi, I'm Susan Zalenski with Johnson & Johnson. Mr. Beal: I'm Chris Beal with Otsuka Pharmaceuticals. Dep. Sec. Dunkel: Thank you all. Are there any announcments? **Announcements:** Dr. Larson: The only announcement, which may be affecting Dr. Esslinger, is the no parking to the south of the building. It has a potential for being towed. That's more of a reminder. Dep. Sec. Dunkel: There he is. And Dr. John Esslinger {enters room}. Dep. Sec. Dunkel: I had a request on the agenda, and if everybody is ok with it, we'll do that. Which was to, on the back of the sheet, item IV - Process Improvement Initiatives - For informational purposes only – B. Preferred Prescriber Status; had a request to move that up to prior to the Old Business. Which, I think, we can facilitate from the State side if everybody on the committee is ok with doing that. {No objections heard.}	
IV. Process Improvement Initiatives B. Preferred Prescriber Status	{moved up per Board agreement} **Board Discussion:** Dep. Sec. Dunkel: Ok. We've had a number of conversations. I had meant to get here early so I could catch you guys before this. But it's not much different than the conversation we've had before. So I thought we would be ok. What our intent would be with the policy going back to the conversations we've had in this group last time around would be to basically get preferred prescriber status, just right out of the gate, to the Psychiatrist. And then utilize a process on the back end for kind of a post audit review to identify those that are kind of outlier prescribers. Then have the MCOs approach those folks with conversations about kind of prescribing practices; then make a clinical determination from their perspective whether it was appropriate or not. If there seems to be somebody that is prescribing outside the norm, they can't come to terms with them, they could basically request of KDHE through the KanCare program to revoke that preferred prescriber status for that individual. The conversation we had internally was, that would be something that we would look to do across all three, across the KanCare spectrum not just MCO by MCO. So if a provider, you know, for some reason, had done something that would require us to revoke that and it was pulled back from, you know, say Amerigroup, then United and Sunflower would have the same situation where the provider	For informational purposes only.

wouldn't have to think 'Do I have? Do I not have?'; just make it a KanCare revocation as opposed to an MCO by MCO revocation. That would be kind of the Phase 1.

I think for Phase 2, that goes back to the conversation we had before. Where we need to flush it out a little bit more. And do a little bit more research on the prescribing practices around the APRN and Primary Care Docs. And then come up with a plan for rolling those folks into the preferred prescriber grouping.

Ms. Cobb: And just to take this back a little bit, my understanding is those only come into play when we're setting the limits that we have. I mean, when we are setting the, like '3 or more' or '2 or more'. Depending on which one. Those are the only times those come into play as far as the PA?

Dep. Sec. Dunkel: Absolutely. Yes. So this would be for just for the things that are outside of the criteria that we're setting here within this body. And then, of course, being set by DUR.

Dr. Esslinger: Well, in general, I would expect that the Psychiatrist would be excellent prescribers as a group. They're unlikely to prescribe a drug that's not appropriate or indicated, I guess, we could parse it down a little bit the one thing is there's maybe 2 drugs that can do the job. And if it's a new patient that's not been on that drug class before, some may choose the brand name some may choose the generic. Would there not be a reason to try the generic first? Even for the Psychiatrist?

Dr. Larson: Are you referencing as Step Therapy comes in to play more? Step Therapy did pass. I don't know if everybody is aware of that. Or read about it. But all the mental health drugs for Step Therapy edits will come through this group. Is that what you are speaking to?

Dr. Esslinger: Yes.

Dr. Larson: Then would the Psychiatrists be exempt from Step Therapy as well? Is that true in accordance with this Gold Card or Preferred Prescriber Status?

Dr. Adma: In my thinking those are two different things. Because that did not come to the committee yet. Right? For us to absorb. What would that impact? What we are talking about is the pre-authorizations that are currently in play that we are talking about. We have in our past committee meetings talked about the preferred prescriber status and thought that if start off as, you know, it was rightfully pointed out, phase one approach. Which would be can we say all Psychiatrists they don't have to go through this preauthorization process. But we would identify these for other practitioners. When you look at the data, 60% of these prescriptions outside of the limits are being prescribed by Primary Care Physician, a Pediatrician, or a Nurse Practitioner. A Family Nurse Practitioner not even a Psychiatry Nurse Practitioner, is that correct?

Dr. Larson: Yes. And actually in response; the group had asked last time for information specific to the criteria that was passed. I do have that criteria right now if the group were interested in seeing it.

Dr. Porter: Just to wrap up Dr. Esslinger comments; so, if we go forward with preferred prescriber status, we would be, it would not be necessarily opting us out of any step edit; a Psychiatrist out of any step edit. So we, later, actually talk about it.

Dr. Adma: We will actually will talk about it when it comes to it. Because right now, it's not on the table, right?

Dep. Sec. Dunkel: From a procedural standpoint, I believe, as you're having those conversations around the step therapy components, once we get there, it would be part of the indication on the policies would be does preferred prescriber status apply to this or not.

Dr. Porter: I think that's fair.

Dr. Ellermeier: That sounds reasonable.

Dr. Esslinger: Yes, I think that's an important consideration. As Dr. Adma said, 60% is done by Primary Care Docs. The only other thing that would be of concern would be is that you're a Psychiatrist, you're prescribing for a patient, you don't know if that patient is seeing two other Docs who are also prescribing the same drugs, and how do you protect against that? Because you probably wouldn't want to put that patient on a third antipsychotic if they're already on two.

Dr. Adma: And they are seeing two other doctors who are Psychiatrists or Non-Psychiatrists?

Dr. Esslinger: Let's say non-Psychiatrists for a first case.

Dr. Larson: And we did see that within the data. You'll see on each of them, it varied by percent. But sometimes it was 20% of the patients were it was from more than one prescriber. We did not break it down to see if it was two psychiatrists or a psychiatrist and a family practice physician. But we did see it vary depending on criteria, that it was more than one physician.

Dr. Adma: And this would catch it because the PCP would not be able to pass it through the pre authorization process right? If the PCP is prescribing the second and third antipsychotic medication?
Dr. Esslinger: If the Psychiatrist is prescribing the second and the third, then it would not.

Dr. Ellermeier: What if…

Ms. Cobb: If they had a PCP.

	Dr. Adma: Then a Psychiatrist would know in those situations, 'hey you know there's something wrong here; we need to dig through these three antipsychotics'. Dr. Esslinger: Not if we're not prior authoring Psychiatrists. Dr. Ellermeier: Right. So if we have a gold card, then you wouldn't know about that. That claim would just pass through. Right? So you wouldn't know about this. So if you didn't know from the member that they were taking antipsychotics from, you know, their primary doctor and for some reason you decided to prescribe that third one, and we put you in the preferred provider then the computer system will bypass that. And won't cause the claim to stop. So you would not know unless the member told you or you got records from wherever else, right? But the pharmacy claim system would not stop, to alert you. That's what. Dr. Millhuff: As a Child Psychiatrist, I wonder how often that's really going to happen. Dr. Adma: Yeah. Dr. Larson: Another thing is… Dr. Millhuff: I mean, Primary Cares are already, sort of, nervous about prescribing antipsychotics to a school age child or, you know, or a middle school age child. Are they really going to be a lot of other PCPs writing meds? That's the Child Psychologist standpoint. Dr. Esslinger: It is 60% of the time. Some of those are kids. I'm all for reducing as much hassle as we can. Believe me. I really am, because it's a hassle on both sides. But I think Jennifer's got some numbers from us in terms of the criteria that you've established for duplicate therapy and so forth. The number of patients in United Healthcare that hit that are in the 20 or less range of patients. That's out of 130,000 patients within our health plan. So it's 25; I don't remember, Jennifer, how many you said, but; for certain drugs, antipsychotic dosing limits, for example, totally unique members: 26. Concurrent Benzodiazepines use; what's the total there? Just four. Concurrent SSRI use, a total of 25. Concurrent SNRI use: 23. Concurrent Antidepressant use: 37. And the totally unique members that are on antipsychotics in children: 1,000. So that's less than one percent. And that's the biggest one. Much of those are a fraction of one percent. So, again, I respect the concern that you have about our prior auth process but the alternatives may not solve one of our main concerns here which is trying to avoid inappropriate therapy in kids. That's my main concern. And adults. Dr. Larson: So here's the overall, for instance, so I compiled the information on all three MCOs. So for the current policy that's been approved on multiple concurrent SSRIs there are basically, what I have here the total population, that's how many people we have on one SSRI. We have almost 19, 000 people on an SSRI. Out of that, 59, across all three MCOs, have the potential for hitting the edit. And it's broken down then by	

	age group, and then by providers. So you can see here, and I did the percentages on the other side. So the majority is 44% Physician, non-psychiatric specialty. Psychiatrist was 30%. Mid-level Non-Psych – 11%. And then a Mid-level with a Psychiatric indication was 16%. So you can see how many from that particular SSRI one. Dr. Adma: So this is a Psychiatrist or Non-Psychiatrist prescribing two SSRIs at one time? Dr. Larson: Correct. So you can see here we have, because we have 59 members and 62 prescribers. So on this one it normally was the same prescriber, but we did have 3 members that had more than one prescriber. Dr. Adma: Is there a way in this data for you to say maybe one is being tapered down; one is being titrated out? Dr. Larson: This was for more than 60 days. This was according to…this was in complete parameters of the guidance that has been approved by this committee. So, it could have been tapering but that would have been longer than a 60 day taper. Dr. Porter: What was the number of people that had different providers/prescribers? Dr. Larson: From what I can defiantly tell on this one, at least 3 because we had 62 providers and 59 individuals. Dr. Adma: And all we are saying, in this scenario, 62 these are the prescribers. Right? Dr. Larson: Yes. Dr. Adma: So all that we are saying is that if we had this gold card system, could we go with, you know, saying that 18 prescribers will not go through the pre authorization process at this time but the rest of the other providers will go through that process - phase one. Let's see how that goes. Whether than put all the 62 providers as requiring pre authorization at this point in time. Dr. Larson: So here's the other. On SNRIs out of 4,800 members we had 47. Here you see a bit more. We had 47 individuals and 63 prescribers. So as you can see it's a larger number then that are having duplicate. You can see the breakdown on the other side. On anti-depressants. Out of 25,000 individuals on anti-depressants, we had 70 members. This was on the 3 or more, this is the overall criteria, if you remember correctly. So we had 70 members and 105 prescribers. And then again the breakdown.	

	Dr. Adma: So in this, with this gold card system, we're having essentially 75% of the prescribers in this scenario. Because the Psychiatrists are prescribing 25, um, What I'm saying is, if we take it one step at a time it might be a good approach. Dr. Larson: And then for the Benzodiazepines, with 4,800 members, 7 of them on 3 or more concurrently, 13 prescribers. No Psychiatrists. For the Anti-psychotics for under 13, out of 16,000 members we actually had almost 3,700. This is because everybody under the age of 13 has the potential to hit the edit. So that's basically including all the members under the age of 13. That's why that number is so high. Dr. Adma: So is that all Psychiatrists who are seeing kids less than 13? The 212? Dr. Larson: So, 27% of the scripts for under the age of 13 came from Psychiatrists. So that's 73% of prescriptions for children under the age of 13 did not come from Psychiatrists for anti-psychotics. Dr. Millhuff: Tell me again what this is? Dr. Larson: This is under the age of 13. Dr. Millhuff: This is for multiple? Dr. Larson: No, this is technically for any edit. Because there is so many different criteria about the lab values and… Dr. Millhuff: What proportion has been Psychiatrists? Dr. Larson: So this is kind of an overall picture. 27% of the prescriptions for under the 13 are being prescribed by Psychiatrists. Dr. Adma: So that's a huge percentage... Dr. Millhuff: Do you break it down for even for younger than that? Dr. Larson: No, I just have; So here you can see our members, like for instance we had 219 from Zero to Five, but I don't have it broken down in each of those categories, no. Dr. Porter: Well what these get to is the idea that we have preferred provider status is brought up that if the Psychiatrist who's got the preferred provider status is last behind the Psychiatrist or Primary Care doctors who are writing the first one or two prescriptions, then if we have that status, we won't be notified that now we have the third anti-psychotic on board or the second SSRI and the number we saw of times that would	

	have happened. We didn't know how many of the three, there were three times with the SSRIs that they were different providers involved in two of them. We don't know how many of those three times it was the Psychiatrist last, which is the worrisome scenario that's been brought up. That's just one class, we have other classes. So that's the reason. The discussion here is does that scenario, whatever danger you think or problem comes with that scenario, is that enough to change or walk away from the preferred provider idea. Is that where we are with this? Dr. Larson: The only thing I can say is it would then catch on the next one. So for instance, then if that prescription came up for a refill, and the Physician is the next one, it'll catch on that one. See what I'm saying? On the next fill. Dep. Sec. Dunkel: And from; I'm asking the MCOs; from an operational perspective, there's still no reason that you couldn't capture the fact that there's somebody that just received something that would have been a violation of like this, would have received the 3rd prescription. You could then notify the Psychiatrist or whoever that third provider, well, in this case, it would have been caught at and through PA, unless it is a Psychiatrist. So then you could reach out to the Psychiatrist and say, I know this is kind of the horse left the barn type thing, but it's still about being able to notify them that 'Are you aware that this happened?' and having that conversation. Dr. Smith: Obviously, we'll do whatever the committee thinks. The way I kind of look at these criteria, we've kind of got two separate sets of criteria. We've got the outlier criteria, right? Which is the multiple concurrent benzos, in which, is this situation of 3 or more really appropriate, no matter who writes that, right? Versus anti-psychotics for kids 13 and under, which there's many situations that's appropriate and this is more just a preventative screening. So, for me, this criteria makes all the sense in the world, plus, just from a sheer volume standpoint, to have a gold card, right? You don't want the quality providers to be hindered by this. It's a huge volume. But on the other hand with the other ones; I think Dr. Esslinger was getting to that point too, doesn't really matter to me if it's a Psychiatrist or not, if it's adding on a third benzo or a third SNRI and the volume is so low on those should those just be excluded from the gold card program as safety criteria, where this is an absolutely burdensome PA volume. Dr. Adma: Than comes, then for each of those we have to decide; 'Well would this require a gold card system or not?' and if not, why? And then rationalize, so go through that. So it would be like a two-step process. Dr. Smith: Could be, yep. Dr. Ellermeier: I think basically it would be; 'Is this eligible for the gold card or not?' kind of deal when we are looking at criteria. That makes sense to me in the fact that some of them we're looking at a very small sub	

	set of patients that really even the committee when we discussed them had a really hard time coming up with a scenario when it was appropriate. Whereas this one, it's very often appropriate. Dr. Adam: We are all for improving safety. I think that should be the first thing, but, at the same time we don't want the pre-authorization process to be burdensome for you as well as the Psychiatrist. Dr. Esslinger: What we really don't want though is the patients to be in a situation, none of us want a patient to be, by error, taken off something that's working. That's the main thing we don't want to happen in this process. Dr. Adma: This is, by the way, very good information, Liane, very good. Dr. Larson: Thank you. Dr. Larson: And this was the last one, in terms of the dosing. This was the anti-psychotic dosing limit. So, out of 16,000 members on anti-psychotics, we had 90 members over the dosing limit. Dr. Adma: Of those 90, 2/3 are non-Psychiatrists? Dr. Ellermeier: Yeah, and there; is that right? There were 86 unique prescribers? Dr. Larson: And then there were 86 unique prescribers, correct. Dr. Ellermeier: So it's maybe not one prescriber doing all of it, but whether… Dr. Larson: But some of them could be for the fact that we had 6 to 12 year olds over the adult limits that we've set. Dr. Adma: And the other challenge is because of the limited number of Psychiatrists out there, especially I see it in the foster care population, When they move, then the PCP takes over and prescribes whatever the Psychiatrist prescribed before but they do it lethal. That's another challenge. Dep. Sec. Dunkel: Ok, We'll take that input back. Really it sounds like the question we have left to answer is; 'Do we have some of these policies that still would be outside of the gold card around is it the benzos or is it those pieces?' What we'll plan on doing is having the final policy for distribution at least on the Phase One, and kind of the intent of Phase Two, and if there's a Phase Three, ready for this next meeting. Dr. Millhuff: Are there examples from other States that are using this sort of method, for preferred or exempt prescriber status?	

Dr. Smith: Ohio just rolled out for Psychiatrists, for certain criteria, they are excluded. For Behavioral Health. I'll send that out. I'll send it to Aaron and Liane. They just came out with it this year.

Dr. Millhuff: Excuse me, I was wondering behind the scenes in these other States, where they have these pretty clear guidelines, are the managed care organizations, do they have a method that's not so public that does excuse certain prescribers? Does anybody know that?

Dr. Esslinger: I don't know that. When I did Medicaid in another State the challenge was every bit as great as what we see here. In that case we had one Pediatrician who had essentially been practicing Child Psychiatry for a long time. She was the one that many Primaries referred to for their tough cases. She called me one time and said here's what my population looks like; here's the things that are driving me crazy and I found a way to get her gold carded, functionally. I think the challenge for any of us; this is great information, by the way, if we get to that one pie chart that showed that the majority of prescribing by Psychiatrists, and I'm going to take it on faith that it makes sense that's what those patients need, and so that would be a target rich environment for gold carding. Some of these other areas, I think, maybe not so much, because you might want to cast the net wide. When you look at the numbers, when we authorize this once, it's good for what…Jonalan? Jennifer? Six months? Twelve months?

Dr. Murff: Depending on the…

Dr. Larson: Most of them are a year.

Dr. Esslinger: And so, the numbers are relatively small. That's for all three MCOs. So once you get your authorization, even if you did have to prior auth, it's good for a pretty considerable period of time. Just want the Committee to keep that in mind as well when we're thinking through this. In general, I would say, the higher percentage of prescribers that are Psychiatrists, the more opportunity, I think, that there is to consider gold carding. If that makes sense.

Ms. Cobb: But I also think, too, if you have a skilled mental health Nurse Practitioner, that this is their specialty we shouldn't necessarily look at that pie chart and say those are inappropriate prescriptions.

Dr. Esslinger: I'd be willing to put Psychiatric Nurse Practitioners in that pile, if you guys are. Do they have a contractor agreement still in the state of Kansas?

Dr. Adma: Collaborative.

Ms. Cobb: Yeah, collaborative practice, yes…

	Dr. Esslinger: They can't practice independently now? Ms. Cobb: (continues) …Yeah, they do. Dr. Esslinger: I think that's best. Dr. Porter: I guess an interesting thing about that, I don't know how fluid it would be in the event that changes as Legislation comes every year, regarding that, it hasn't changed anything. I don't know if we set something in place now about that, that people would feel differently about it if the law changed. I don't know. Dr. Esslinger: I'm big on collaborative practice; even between non Physicians, non NPs and others. That's kind of the direction health is going anyway. So I'm very much for collaboration. Dep. Sec. Dunkel: So, we'll take this back. The piece that we know for sure will be in the policy then will be the fact that Phase One will be Psychiatrists. We'll work some more and probably reach out to you guys, maybe outside the meeting if we have specific questions around the policies that might be exempted from the gold card basically. And get some feedback on that so we can kind of blend that in on the policy. While this body doesn't have to approve those policies, we do want to make sure that everybody here is aware of the way that we're moving forward. So you can take those things into consideration as we look through these different criteria. Dr. Millhuff: I know we're trying to move on; I just want to point out in Texas, one of their triggers for further review of, of a child's clinical status in regards to these psychotropic medicines, is if the Primary Care provider has not documented previous specialty training for diagnosis other than ADHD, uncomplicated anxiety disorders, or uncomplicated depression. So what I'm thinking is, if we're thinking of the second tier, if you are a primary care provider, let's say that Pediatrician that's outstanding or a general psychiatrist who has a lot of experience working with young kids. If you can show that you've have specialty training, conferences and what not, could you then be qualified for this exception? Offer that as an idea. Dep. Sec. Dunkel: We'll defiantly do more reaching out on that conversation around Phase Two and Three. Because Phase One when we really got down into the conversation, the Psychiatrist became relatively easy. Other than this one of the things that was brought up today, did we want to break off some of the safety pieces, I'm glad it came up in this conversation also. As you get into Phase Two and Three you get a little more complicated in how you parse out who is and who isn't and so I think we'll obviously be reaching out some more and probably have Liane contact some of you guys directly and just ask. Obviously you've done some research on it and you know what they're doing with some of the components. And we'll continue to do research on our side.	

II. Old Business A. Review and Approval of February 9, 2016 Meeting Minutes	**Board Discussion:** Dep. Sec. Dunkel: With that we'll go ahead and move on to old business. And in your packet, somewhere, the really, really, big stapled book. Word-for-word transcript of the last meeting. I'm sorry, it cracks me up. I'm glad it's there, it's just really big. Has anybody had a chance to go through it? If you did, do you have any changes, corrections, edits? Dr. Porter: I have a few but they're not of any interest. Just typo things. Dep. Sec. Dunkel: What we're going to do then is go ahead and if you have any edits, concerns, go ahead and send them. Go ahead and turn them into Liane. And what we'll do then is incorporate the edits sent to Liane between now and by the time the next agenda comes out. And we'll make those adjustments and send them back out with the next agenda so we can do approval. There's no reason to hold up a whole lot today unless someone really, really loves minutes.	Tabled to next meeting.
II. Old Business B. Prior Authorization Criteria 1. Use of Benzodiazepines and Buprenorphine Products – Review proposed clinical criteria for medication assisted treatment program patients prescribed benzodiazepines.	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkel: Next we have the Prior Authorization Criteria, number one. Liane? Dr. Larson: The first one we have up is the use of Benzodiazepines and Buprenorphine Products that we've had on the agenda for a couple times. I know last time the committee had asked for some reference information which I forwarded to everyone that Dr. Shoyinka had provided. And so again this criteria would be adding into the condition, into our current policy for Opioid dependence agents: the patient must not be prescribed benzodiazepines concurrently and that it would cause the benzodiazepine claim to deny for 30 days after the last buprenorphine/Naloxone fill. Dr. Ellermeier: I have a question. So on the renewal, they're not allowed to have Opioids filled, but that's just-is that just a retrospective review and not like a system edit? So that this is different in that it would be a system block. Is that correct? Dr. Larson: So, are you talking about if a patient has received Opioids? Dr. Ellermeier: On the renewal portion, where a patient has not received any other narcotic agents since the last prior authorization approval.	Dr. Ellermeier moved to accept the criteria. Dr. Porter seconded the motion. The criteria were unanimously.

	Dr. Larson: And that's what has been written in general for the Opioid overall criteria. It would never deny…based on what we're adding here, it would never deny the Opioid claim. It would only deny the benzo claim. Dr. Ellermeier: Ok, and the Opioid? Dr. Larson: The Opioid would deny because their using the buprenorphine or the buprenorphine/ Naloxone. So they couldn't be getting more than one. Does that answer your question? Dr. Ellermeier: I think so. I guess the narcotics is more of a retrospective look and the benzos are going to be a system edit. Dr. Larson: The benzos are going to be a system edit. Yes. Correct. Dr. Porter: I just want to take note of, I respect the people that have the skill to put this together. One of the things is dangerous to withdraw from, the other is just extremely uncomfortable. And we're automatically stopping the one that actually can be dangerous to be stopped abruptly. I guess this is the way the addiction field thought this needed to be done. So. Ok. Dr. Adma: A friend of mine, that's what he does in his practice. If a patient is on any one of those he tells the patient 'I'm going to taper them off'. Dr. Porter: But it's different to taper somebody off then, depending on the dose, it is to just say you don't get. Dr. Adma: They get 30 days, right? It's approved for 30 days, I guess? Dr. Larson: No, so this one, they would not be…So, let's say you had a patient and you can have different scenarios, so let's say they're on Suboxone and have not previously had a benzo filled; it would deny when they go to have that benzo filled and it would deny for 30 days after the last fill of the Suboxone. Cause in general, if they are getting that for 30 days, we don't want to have a risk of any overlap on it. Now, with that, I would, I can't speak for the MCOs, but I'm guessing, if there's, just as with other overrides, if a Physician or Psychiatrist calls in saying 'I'm aware that this patient; I'm starting them on Suboxone and I'm tapering them off the benzo.', that would be, obviously, taken into consideration for the clinical aspects of that. But otherwise, if they happen to get it from	

	two different providers or whatnot, then it's going to deny that benzo claim. So, with the numbers we have on this one, out 229 patients on a buprenorphine product, 55 of them had both a benzo and a buprenorphine. Dr. Adma: So 25%? Dr. Larson: So 24%. Dr. Adma: So, thoughts? I know you have background, so. Dr. Shoyinka: Sounds reasonable to me. Dr. Adma: But they have to have a 30 day override? So that then they would be a taper? Because if you go with the current system, they could be, you know, be on a high dose of a benzo, or something like that. Dr. Smith: This would be before they get the Suboxone. So they could continue the benzo and not get the Suboxone. But if they are going to get the Suboxone, then the benzo will deny later. So would have to be pretty much a new start to the benzo, right Liane? Dr. Larson: It would have to be a new start. My concern, personally, with the 30 day override is that a patient could start newly on a benzo during their Suboxone treatment. Dr. Ellermeier: I think, I agree with this in theory. My only concern is that there are already 50 patients that are currently doing this. So I'm sure you guys are great at doing the outreach ahead of time, but I think that definitely would have to take place so that providers can attempt to taper patients before it is implemented. Dr. Esslinger: Good point. Dr. Adma: My only concern is really if we do the abrupt stop, is, you know, benzodiazepine withdrawal can be pretty bad. So, compared to the other. So, that's why. Dr. Ellermeier: But so can death from, you know…	

	Dr. Porter: Combination. The thing is we have 55 Kansans who this applies to. Would there be simply no way to give a warning? Until they go to the Pharmacy to pick up the benzo and it stops? Dr. Shoyinka: And that was going to be my comment that anybody that's getting started on buprenorphine, it's after lengthy discussions. So the clinicians could very well taper off the benzos as part of being sort of lead into starting Suboxone. It's not an emergent treatment. Dr. Porter: As long as they know. As long as this information gets to that prescriber and that patient before they go to the pharmacy and it's denied. Dr. Murff: So for any PA criteria that is put in place, I probably shouldn't speak for the other two, I think this is true for them also, is that we identify those members. That are currently on those, right, so we know those 55. So we do some letters to the members, to the prescribers and let them know, 'Hey, by the way, say three months from now we are going to turn this on. So please be proactive and start going there, so you know, you're not surprised at the pharmacy. Ms. Cobb: Cause with 25%, it does seem like a prescriber education issue too. Dr. Ellermeier: I would move to accept the criteria with the changes. Dep. Sec. Dunkle: Second on the motion? Dr. Porter: Second. Dep. Sec. Dunkle: All those in favor - 'Aye'. [Many 'Ayes' are heard.] Dep. Sec. Dunkle: All those opposed; same sign. [Silence] Dep. Sec. Dunkle: Alright.	

II. Old Business B. Prior Authorization Criteria 2. Stimulants and other ADHD Agents Dosing Limits – Review proposed daily dose limits for patients prescribed stimulants and other ADHD agents.	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkle: Next we'll move on to number 2; Stimulants and other ADHD Agents Dosing Limits. Dr. Larson: Ok. This criteria in regards to Stimulants and other ADHD Agents Dosing Limits which was presented last time; I have the changes, sorry it's very small there, here at the table, everyone has the criteria in front of them. Red indicating the changes; the addition of Clonidine and Guanfacine; the removal of ADD; and then the additional dosing limits that went with both of those medications. Dep. Sec. Dunkle: Any additional comments on this criteria? Dr. Adma: There will be a pre authorization required for any dose more than 20mg a day. The 60mg of the Adderall. And then 70mg on Vyvanse. Dr. Millhuff: Are these criteria applicable to any age group? Dr. Larson: This is for any age group, on this particular one, yes. And as we discussed previously, we're bringing it to begin with for all, and then if the committee so wants, we can drill down into looking at specific criteria with children as a 'brought back' review. Dr. Porter: What about 'The prescription must be written by a Psychiatrist'? I don't recall reading a discussion about that. I have the minutes back here. Dr. Larson: This one doesn't have to be… Dr. Porter: I'm looking at the next one. I'm sorry. Dr. Larson: This is just 'Doses exceeding those listed in Table 1 will require prior authorization.' and then the peer-to-peer. Dr. Porter: Ok. Got cha. I'm looking ahead, sorry.	Dr. Adma moved to accept the criteria as amended. Ms. Cobb seconded the motion. The criteria were approved as amended unanimously.

	Dr. Millhuff: Well, I want to say that I think that the dosing criteria needs to take into consideration, not just the ceiling dose, but the starting dose. And I think we need to consider age groups, three to five and then from greater than six. And put more emphasis on where to start with these meds and just where do we cut off the dosing amount. Because that's one of the areas that I think is of greatest concern is these little kids getting started on doses that are adult doses. So, I took the liberty to make some copies of a format that I think works pretty well. That I'd like to share with the group, if that's ok? That's an outline of what Texas is doing. And it breaks it all out in very specific numbers. Not just for what the FDA has approved for dosing limits, but what is also found in the literature. And, what seems to be in terms of expert consensus what doses go above the FDA limit for these different age groups. Is that ok? Dep. Sec. Dunkle: Yes, absolutely, it's part of the conversation on the current criteria. Dr. Millhuff: So, the dosing limits, the nice thing about this guide too is dosing ranges for all these categories we're talking about in kids. Karen actually put an e-mail out to reference this. Stimulants start on page 8. Dr. Esslinger: For the adults? Is there a similar concern for starting doses in adults or not as much? Dr. Adma: Not as much. Dr. Ellermeier: Systematically, how would it work to put in an initial dose limit in place? Would it be with that then basically require a PA for every first fill of a stimulate medication? Dr. Todd: That's a really good question. Have to think about that. Dr. Larson: I would think you'd be able to do a look back within your individual plan. But the only issue may be if you had people change plans or coming into your system as new. How would you know that that wouldn't be an initial? Dr. Todd: But if we need to have a minimum dose though? You'd have to look. I think there's max and mins in the system, I'd have to double check. But I think we have the capabilities without doing like a PA.	

	Dr. Millhuff: I believe all the meds that we have on this list are reflective of here, on these lists here. I looked this over and I thought this would be a little bit more detailed and give us, if you get a pre schooler into the pharmacy and their starting high and you could automatically stop it right there before they start too high. Dr. Adma: Sometimes extended release formulation is combined with a short acting; a small dose of an IR. So would this hit a prior authorization in those situations? Somebody is on Concerta 72 and something else on top? Dr. Smith: If it were two different doses of Concerta. So if you had a 72 and a 27, it would hit. But as written if it were Concerta 72 and Methylphenidate IR, 10mg, it would not. Dr. Todd: Because it's not the concurrent. Dr. Millhuff: And in this, in their guidelines here in Texas, they definitely specify that it's appropriate to use. They're going to ding if you have two or more stimulants going, but they make the exception if you're augmenting with a short acting stimulant as appropriate. Dr. Adma: So, Dr. Millhuff, according to this sheet, if we have a five year old and they are starting off with 5mg a day, then it would hit the PA process, they have to start at 2.5 a day. Dr. Millhuff: Which one are you talking about? Dr. Adma: Adderall. And then they will go to the maximum. They could go, in this scenario, up to 30mg a day of Adderall. Dr. Millhuff: Yea, and there are a few of these that that one was a specific one that didn't make sense to me on a child that young. That was one that stood out initially. But I guess I'm putting this as a template out for us to kind of look at these dosing parameters in a different way. For the most part, when I looked over these numbers, they all looked pretty good to me. Dr. Adma: My only concern from the MCO standpoint is, I think, safety wise the biggest challenge; me and Chip, we see kids all the time, they're being overdosed on these high doses, based on their age. We're not talking about a twenty-five year old; we are talking about a five year old, safety wise that's the biggest challenge that we see. And I think, you see on your side too. So, if we were to go	

	with what you are proposing, it does not matter for a 5 year old somebody can prescribe 72mg of Concerta. Dr. Smith: Not yet. This would be step one. Any limit. Cause right now there's no limit to these drugs at all. You could get 105mg of Concerta. Dr. Larson: And this is definitely something that, with this, I could bring back a template to do specific dosing for children for ADHD medications for the next meeting. Like Jonalan was saying, if you wanted to could view this as a step one putting that max limit in, and then going in and doing a more specific, detail for children. Dr. Adma: It would be helpful for us to look at the data right now of patients and maybe prescribers who are over these limits. Dr. Larson: I don't have the breakdown of this one as I do for the others. I can tell you just with these edits alone, and it's not broken down for children, we have 1,786. Out of 25,000 individuals on ADHD medications and out of that we have 1,786 over the limits. Dr. Adma: Over these limits? Dr. Larson: Over these limits. Dr. Adma: And of those, how many are Psychiatrists and how many are not? Dr. Larson: I don't have that data. Dep. Sec. Dunkle: 7%? Dr. Porter: 1,000 out of… Dr. Larson: Seventeen hundred and… It's like 1,800 out of 25,000. Dr. Adma: So less than 10%.	

	Dr. Ellermeier: So, I agree with you, Chip, I think we need to have lower limits for kids. But if we're talking like starting point of just the highest that we are comfortable with, I think the limits that are proposed today are reasonable. Dep. Sec. Dunkle: So what we can do, kind of like Liane was saying, we can go back and if taking this action on the upper most limits, go back and we'll do some operational conversations with the MCO about being able to set, these lower initial dosage limits versus the maximum-maximum. Figure out exactly how we would handle it from an operational stand point. And put together, maybe borrow this directly and come back and say this is what we would suggest. There'd be conversations around that I'm sure. The operational pieces, the parts that we need, make sure we can contend with that. The taking of that policy then to DUR and implementation. Ms. Cobb: The 7% age group was on... The 7% of greater limits prescribed was on what age group? Dr. Smith: All ages. Dr. Larson: All ages. Dr. Porter: And certainly we'd probably find more with the new criteria. We're going to have lower limits for younger kids. So, we'll more than likely find more. Dr. Larson: You'd probably see more. Dr. Adma: I've looked at these numbers, Chip, most of, I would say, almost all of my prescription will be within this range. Dr. Millhuff: I agree. The only thing that I'd say, Vishal, it's a little different. I've run into this with dose optimization, is when working with very young children, you start low and titrate slowly and my best example is Intuniv and having dosing flexibility, not only to incrementally go up, like weekly increments, but be able to immediately back down with a lower dosing amount. We talked a little bit about that already. We talked about it last time actually. With dose optimization we're limited on some of these meds with that kind of strategy unless we just give a short amount, say a maximum of 30 pills. And there are other meds too, that like Focalin XR we commonly use it twice a day, not common, we use it periodically twice a day. We think of that as conservative as well.	

	Dr. Adma: If we're thinking about Focalin XR twice a day, is 40mg the maximum daily allowed dose, is that what you're thinking? So, like, 20mg in the morning and 20 in the afternoon? Dr. Smith: It'd still be ok within this; as a total daily dose. Right, Liane? Dr. Larson: Now if you ordered 3 times a day… Dr. Smith: You'd have to drop it to 10mg. Dr. Millhuff: One other thing that I would say about a specific med, is the Intuniv, this is something I've checked around with a few people, Vishal, I'm curious about you, but, Kapvay is kind of long acting Clonidine is kind of set a pattern for BID dosing. Many of us have used Clonidine QID in short acting form as we have Guanfacine and I, just again, find that with QD dosing of alpha two agonist sometimes these kids can't handle a onetime shot of this drug and we have to spread it out into BID dosing. I've run into that with the stimulants as well. I can't get that whole day covered without splitting it out, so I'm just a little bit concerned and want to make sure we're looking at the quantity limits of the pills, which we run into the dose optimization issue. Dr. Larson: But this wouldn't look at any terms, it would just be looking at strength. So it would take that 7mg times your 30 day; would not be able to prescribe 210mg, however that be divided. Dr. Millhuff: So you could do 2mg, twice a day, of Intuniv? Dr. Larson: Isn't that one off? Dr. Smith: That one is not off. The 1 is off and 3 and 4 are open. Dr. Larson: Yea. So on that one-no, but that would hit because of dose op, not because of this. Dr. Millhuff: Right, but, I guess as a clinician, I'm saying that from the practice standpoint, there's a conflict there in terms of optimizing both safety and efficacy. The optimization program is limiting that on that specific dosing. Dr. Larson: But even if this was not in place, that still would not be allowed. Dr. Millhuff: Why's that?	

	Dr. Larson: Because if dose optimization, doing two 2mg tablets, this has no bearing on that. Doing 7, that's because of dose optimization not because of daily dose limits. Dr. Millhuff: Right, so, we as a committee here are reviewing the use of these medicines in general. I'm just trying to represent that and in terms of developing these criteria we're talking about, how these drugs are used in the kids, I'm trying to build that in to the overall parameters that we're setting. Dep. Sec. Dunkle: I would say we probably, I mean, dose optimization, while a good conversation to have, I think, from a general operations and practice standpoint, isn't really under the purview of this group. Now, we can have that conversation of how it affects some of the criteria probably, but I think, just from a general policy standpoint, we won't be bringing dose optimization to this body as a policy discussion. Dr. Millhuff: So dose optimization trumps clinical experience and utility. Am I hearing you right? It supersedes that? Dep. Sec. Dunkle: I'm not saying it should supersede, I'm just saying it's not the purview of this group to talk about dose optimization necessarily. Dr. Millhuff: Ok. So if I propose that we make this specific medicine a BID dose here, could we approve it that way? Dr. Larson: It would still fall under the dose optimization. And with that, I would say, for instance; help me remember which ones we did take off, I can't remember. Is it the 1mg? For instance, at the beginning, we did put in dose optimization; the 1mg Intuniv. And we did hear clinical feedback that: hey we do need to be able to use this more than once a day. So we did remove that then from the dose optimization policy. So I would say defiantly that clinical judgment does not override for dose optimization. I think that's a fair example of how we are trying to be thoughtful about that and to make those changes. But dose optimization being separately with the 2mg dose still on it, wouldn't have an impact in terms of the 7mg daily limit. So I would think what I would say to that is that, again, we want to be looking at it clinically and what is appropriate. That's why, for instance, the 1mg was taken off dose optimization. Now, if we have to have that conversation around the 2mg, I would agree, because that doesn't come through the Mental Health Medication Advisory	

	Committee, would be a separate conversation to have outside this committee. Because that wouldn't have any bearing on having a 7mg daily limit on the medication. Dr. Adma: So if 1mg was taken off, can somebody write; 1mg-2 tablets in the morning and 2 tablets at night and it'll go through? Dr. Smith: It was increased to 2. Dr. Larson: Oh was it increased to 2? Dr. Smith: To 2. And I think the primary reason was because of the titrations, right? That's when it's really killing you; it's like 1 a day for two weeks, then 2 a day, trying to get that optimal dose. Then you find out 'oh, that's too much.' Go back to the 1; you can't break them in half, so I think that's the 1. The 2s, I think it was kind of like if you are using more than one 2, you are splitting it twice a day. And then is there a chance to consolidate it or provide rational? Dr. Millhuff: So, Jonalan, so if I have a six year old, let's say, an eight year old on [?], I've titrated up to 4mg on Intuniv, they're too sedated by it and 3mg isn't enough, what are my options if I want to look for better tolerability and more even coverage? Is there any way I can achieve that? Dr. Smith: So 1 is the PA for 2mg twice a day, another would be, 3mg in the morning, one at noon, that would not hit, could do combination ER-IR that would not hit. Dr. Millhuff: In Kapvay, you can do 2mg twice a day? Right? Dr. Smith: Correct. Dr. Porter: It's FDA approved that way. Dr. Smith: It has a shorter half life. Dr. Millhuff: That's part of my argument here is, can we please just maybe write however you made the ones available can you make the twos that way? Dr. Smith: We can take it back.	

	Dr. Larson: I can take it back and we'll take a look at it and pull some information. Dep. Sec. Dunkle: So back on in the criteria, we'll go back and we'll pull, we'll reformat this in kind of a Kansas format. What we'll do is have Liane run some numbers again showing where we would be as far as how many outliers we'd see in this kind of structure, because obviously there's a number even at the highest dosing limits and so we'll see what it does with the rest with these initial dosing limits. What's the rule of the body on the criteria before you today? Dr. Millhuff: I still think there's dosing numbers here that are too low. For instance, Concerta, I think we should make the top end 108. Dr. Esslinger: What I would suggest, Aaron, is that Dr. Millhuff make some suggested changes to the document that he handed out. Have the committee think about that prior to the next meeting. And perhaps we can… Dr. Smith: It would be nice if we could get some sort of max limits in, soon, because, again, it has to go to the DUR after this. So even if it's higher than that, like the 108 would be, what is that plus? Dr. Ellermeier: I think that there is only three that the current limits disagree with these. That was Concerta, Methylphenidate IR, it was up to 100 if you're greater than 50kg and then Focalin XR was 50 versus 40. I think those were the only 3. Dr. Millhuff: Did you catch those, Liane? Dr. Larson: No. I got the Concerta, and what else was there? Dr. Ellermeier: The Focalin XR to 50mg. The Methylphenidate IR to 100mg. Dr. Millhuff: That was for, if I read this correctly, they had 100mg for all these not just the IR. Metadate ER, Methylin ER, Ritalin SR, on page 9. Dr. Larson: So take out 60 and add it to be 100? Dr. Millhuff: This is for…yea.	

	Dr. Ellermeier: Yea. Dr. Larson: And then also for…set these for ER and IR, correct? Dr. Ellermeier: Yep. Dr. Millhuff: Oh, for the kids. So essentially for all the Methylphenidate products, it looks like except for Daytrana Patch, 100mg was the limit they put on this other one. How does that sound to you, Vishal? Dr. Adma: Fine. Dr. Millhuff: I mean, purposely set a high number. Dr. Adma: I usually use less of a dose. Dr. Millhuff: I do too. I do too, but this is, like you said, Jonalan, to start high. Dr. Smith: Yep. Set a cap. Dr. Larson: So are these the changes you want, I just want to make sure this is correct: So on the Focalin XR, change it from 40 to 50; for the Methylphenidate, I have from 60 to 100; on the Methylphenidate ER also from 60 to 100; and then on the Concerta, I have from 72 to 108. Dep. Sec. Dunkel: Is there anybody on the Committee that disagrees with any of those changes? Seeing none, do we have a motion to accept? Dr. Adma: I do. Dep. Sec. Dunkel: Motion. Second? Ms. Cobb: Second. Dr. Porter: I have a discussion point.	

	Dep. Sec. Dunkel: Ok. More discussion. Dr. Porter: When we approve these, we're focusing on the top part of the page with all the medication on it. I think the bottom part is important. I'm sorry for going sideways on this, but I think that this would be a good point before we approve more criteria. That the notifications about the anti-psychotic use in children went out after it went through here and we really hadn't done something very important which was to look at the bottom little paragraphs and say what's going to happen when these go out. I think that's something to announce that their back on hold at least one of the MCOs said. But, for example there's a line in those limits, it's not limits, pardon me, in that part of our discussion that said 'you must show a certain amount of psychiatric involvement', in these cases. They have to had failed behavioral therapy. Not that those are terrible criteria, but the point was, how is this going to be communicated to an MCO? What are we supposed to tell people and how? Could we get a standard form? Could we…these are getting ready to do out. And people had no idea how they were supposed to document adequately that the person had failed behavioral therapy, for example. This makes sense what I'm bringing up as a concern right now. I think when we send these out, if it's true that we are approving these, and later go and look at the process, which is what I thought we were going to do, before anything is actually released to the clinicians and consumers, that's one thing, but if these things are going to go out piece by piece as we go through them, then we have to stop and look at the bottom part and how that's actually going to…rubber is going to meet the road. Dr. Ellermeier: To me, we're approving what the criteria is, and then it's up to the MCOs to make that operational. So, the criteria here is that if you're above that limit, the limits that we have just set, that a prior authorization would require a peer-to-peer consult. Dr. Porter: I still think that we have a safety issue. I think clinicians are here, I think everybody cares about patients here, I think that you're saying that's not our place to say, but, again, there's a, we could at least bring up the fact that if you send that out to people and say you must document these, I'm not actually talking about the broader criteria, not the limits, let me refer to them as the safety ones and then the ones that have to do with the age. Dr. Ellermeier: Like, the monitoring ones?	

	Dr. Porter: Yes, the monitoring ones. That's a better way to put it. The monitoring ones say these have these criteria that the people in the field really didn't know what to do with when they came out. Again, what are they supposed to do to make sure the patient doesn't get taken off their medication because of these criteria? Dr. Millhuff: Do you mean taken off them abruptly? Dr. Porter: Well, what I mean, is prior auth means more than 60 days or whatever we decide, that they're not going to be able to continue the medicine unless the clinician, in some manner, has communicated these specific criteria, sorry I don't have them in front of me today, the ones to do with did the patient have adequate behavioral therapy… Dr. Smith: So your concern was what is behavioral therapy? Dr. Porter: I mean, I do know what… Dr. Smith: I mean to document. Dr. Porter: Let's say you've done good care. These are reasonable things to wonder about for a small child. That they've had this. Just so it cuts down on the communication on both ends, what are the MCOs going to want? Dr. Smith: So, I think, yea, we can implement that but you guys can further clarify that if you want in that criteria, so if you want to say, for example, examples of behavioral therapy include this or this will suffice, absolutely if you want to add those, I think the more clear the better. Dr. Porter: Even a standard form to say these are the things that we need in this age range for monitoring purposes. I think would make it a lot less disruptive and potentially, you know, we could send the wrong criteria and that could take time and the person be off their meds. Dr. Larson: I just want to say two things to that. Is that members that were already on their medications, they were not affected; they were grandfathered for a year. So there was nobody who was going to be taken off of medications when that was coming out. Dr. Porter: Still, at a year, is going to be the same. It could be quite a few at the same time in a year.	

	Dr. Larson: That would halve the time. It would be new starts in terms of… I mean the MCOs do have a process in place whether it be… But like Jonalan was saying, if the group wants to indicate, for instance, it could be writing something that says 'verbal confirmation of behavioral therapy'. And that would be the only thing on the form for the prescriber to indicate 'yes, verbal confirmation of'. And if it wants to go that far, it can. Otherwise it's going to be each of their three forms are going to be different, just as it is for all PA because they have to adhere to the criteria that has been sent out. In addition, to the 60 day, I think it was a 30 day or a 60 day override on that one for new starts, it also was a year grandfathering for the old. The intent was not to be abruptly stopping anybody on medications. Ms. Cobb: Where did that criteria come from? Dr. Larson: Which criteria? Ms. Cobb: Well, the one that Dr. Porter is talking about. Dr. Porter: That I orally stated. Dr. Larson: That was through here. That was the criteria that was approved through Mental Health Medication Advisory Committee for anti-psychotics in children. Ms. Cobb: Ok. So you're just applying it to; you're just making the example. Dr. Larson: That was a previous criteria that was approved in October or December. Ms. Cobb: That wasn't anything specific to… Dr. Porter: I'm trying to rewind, I guess something that we already did that cause some problems. Dr. Murff: If I may, as an example with Suboxone. Criteria includes that the patient is receiving addiction supportive therapy. And that is a verbal attestation. So for the criteria for, there are black and white criteria, which would be serum blood glucose or the…there are things were we would need those values. But then for the 'is there behavioral therapy occurring', then that would be a verbal attestation. If it was from the Psychiatry office, then that would be. And if it was a Primary	

	Care then they might as the name of the prescriber that's providing that therapy, I don't think that it's going to go deeper into, more in depth of the treatment or the effectiveness of the therapy, but rather the presence, the fact that this modality is being perused as well as the medication. Dr. Adma: If in your system if somebody already has an assigned therapist then would that automatically take into consideration where the outpatient Psychiatrist would have to provide that information. Because in your system, in your billing system, if they already have the therapist and you are getting billings from the therapist then they are getting that therapy, right? Dr. Smith: Yes. Dr. Adma: Why ask that question again? Dr. Smith: The pharmacy claim system is separate from the medical claim system. Dr. Adma: They don't talk. Dr. Smith: But, that's a great point. Dr. Shoyinka: I wonder if it's as simple as a just a written documentation in the notes. Dr. Todd: At Amerigroup, it's just a yes/no checkbox. Have they had it? Yes. Have they not? No. Dr. Ellermeier: We talked about that criteria, I thought we talked about the fact that we don't want there to be like chart notes or documentation of specific things, we just wanted it to be a checkbox. So I was under the impression that we already discussed that. Dr. Porter: I just know that when these criteria came to us and were to have started 10 days ago, and at that point it didn't say anything about how a clinician, maybe they didn't even know about this committee, they're just getting this announcement in their e-mail that this is going to change, or in the mail and it didn't say how. I think that when we roll, if we do have ways to make this work, we should roll that out with the information that we're going to have a prior auth, is how do you, especially these monitoring ones, these are different. Dr. Smith: How do you do a prior auth?	

	Dr. Porter: How do you do the monitoring prior auth., basically needs to be sent out with the news. Dr. Ellermeier: So, perhaps the forms are attached with the notifications? Dr. Porter: That would decrease panic a bit, I think, wouldn't it? Dep. Sec. Dunkle: We can talk through that between the MCOs and the State and bring that back, just kind of on an implementation, depending on how that needs to work. Because obviously I don't know how much conversation that went on prior to those notices going out this time as to exactly what had to be in them. Dr. Larson: We just went with our standard. In terms of the notifications that do come out from the MCOs, I do approve before going out. It's just our standard as it would be if we were putting prior auth on any drug. It's the same exact; they have to give 30 days notice, it has to state what it was and actually, the MCOs kind of went above and beyond what is our standard process because they actually included the criteria in the notification that went out. Normally that's not the case. Normally it's just 'these drugs are going to be requiring prior authorization' and that's the end of the initial communication. I think they really were trying to get as much information out there as possible shown by including the criteria in that notification that went out. Dr. Adma: Now that you're talking about the processes; one of the challenges from the way we, who the group that we represents, obviously MCOs are going to keep doing whatever they're doing to provide information to their members about all these changes coming up as well as their providers. It would be also helpful, because I represent Kansas Psychiatric Society, so there are about 200 Psychiatrists who are members. Wouldn't it be nice as well as Associations of Community Mental Health Centers, Nurse Practitioner Associations, if there is a way that even through our bodies, we can provide that 'hey this might be something that might be coming up' so our members might at least know from our associations about changes to express, not just MCOs or the State sending this information out. Something for us to think about too. And I don't know what would be the right timing because the company doesn't make all the rules, right? Then there's the Board and then the…we don't want to be premature and this is what's coming out and that doesn't go through.	

	Dep. Sec. Dunkle: Because of the fact that this is kind of a new territory for a lot of the practitioners we are talking about here, I think, around the prior auth and some of the things we're requiring, we'll sit down with the MCOs and talk a little bit about either more education or a more complete packet that goes out, kind of to your point, Ty. Then it's as, you know, 'here's the form you fill out, here's who you need to call to get more information' or whatever it is, to get it more communicative. Dr. Todd: I'm sorry. I was just going to say that Amerigroup, we just published, it either went out yesterday or it's going out today, but we have an information sheet that's being faxed and mailed to all providers and it's already on our provider website and it steps through all the PA processes, all those very specific things regarding mental health drugs. So it's very specific and we tried to back it down to, you know, because there's a lot of folks that maybe don't know all those processes. Dep. Sec. Dunkle: And we'll work with everybody to make sure there's something like that across all three. Kind of eliminate some additional concerns. Dr. Millhuff: Is there any discussion about the KanCare as a whole having web based education materials around psychotropic medicines so it's not one MCO versus another but that we've, in a unified way, taken a step to outline these parameters so that prescribers throughout the state can look online and understand this. Dr. Larson: It's actually on the KDHE Pharmacy website. So all criteria, including mental health, normally I won't put it up until it's actually going into effect. But even with the one that did go out, I already had it up on the website. So you can go out to the KDHE Pharmacy website and see all. It's actually going to look exactly like what you've approved, just taken the signature block off of it and it's on the website for any practitioner to see. Dr. Todd: And Dr. Millhuff that's another point that I'm glad you brought up. One thing that we did with the dose optimization is that we actually held webinars for our providers. We had the community mental health centers call in, a lot of the folks that were working the office, working all of those claims, and so they called in with questions and specific questions, if they had. And that seemed to work out really well. So I don't know if that would be something, and of course, spontaneous, I'm sure we could work with Jonalan and Jennifer and maybe we could have a joint webinar.	

	Ms. Cobb: Yea, because one thing to keep in mind as prescribers, we have the wide, wide range of criteria to fulfill and three different ones, three different, it's a lot. So, as much uniformity as there can be. Dr. Todd: The one good point is that it is one criteria. Ms. Cobb: In this case. Dr. Todd: In this case, right. So if we had one webinar. Dr. Porter: Hopefully one process, even one form. Or something that looks the same with a different number on the bottom would be really helpful, I think. Dep. Sec. Dunkle: I'd like to get back on the agenda. I'm glad we had the conversation. It gives us some information to go back and do some education and some additional talk internally about operationalization of some of these others that are coming up. I'm going to take a huge liberty here with anything that looks like Roberts Rules of Order; we had a motion and a second on the floor on the ADHD age and dosing limits criteria. Is there any additional conversation? Dr. Millhuff: My only discomfort is these high limits and there being no specification what we're passing today, that what's coming down the line. Makes me uneasy someone sees these numbers out there, and says 'you mean you're approving that kind of dosing limit for all ages'. I wish we had a more comprehensive sort of set of, you know, limits that were more specific set of limits that we were approving today. Dr. Ellermeier: Would there be a way, on the website, rather than, I know that we have the criteria out there, but I think that, this Texas doctor has been referenced several times, is there a way to maybe direct traffic to like 'say hey we think these are good guidelines to start from' or have information out there rather than just the criteria, more of an education piece. Dep. Sec. Dunkle: I would say until we actually make it policy, it's really difficult for us to put things out there as guidelines. Dr. Millhuff: So it makes it uncomfortable. It feels like we're approving just a piece of the pie with these stimulants. And we'll get back to it somewhere down the road. It's kind of like these anti-	

	psychotic medicines for kids younger than 13; there are still some important issues that haven't been fully flushed out. Dr. Porter: I think the thing is though, right now, there is no limits. If we put this in place there's at least the warning shot that you're not going higher than this, then we'll come back and put in the age specific things based on this. Dr. Larson: Currently we have 1,800 members above these limits. Dr. Adma: Now is there any grandfathering on this too? Dr. Todd: There would be grandfathering. Dr. Larson: The thing is, that's if they're on a stable dose. That is true. If somebody, if you change dosing, it's no longer grandfathered. Because that's not considered stable dose any longer. But as long as you have, if somebody above the limit on Concerta and they've been on it for 2 years and you keep them on that, then they are grandfathered for the year. And that year is given to be able to reassess it clinically to take a look and see if that's appropriate or not. But yes, with all of these, grandfathering does occur. Dep. Sec. Dunkle: Again, there'd be some post audit by the MCOs and call up and say, 'we noticed in our post audit'. Dr. Adma: All of your concerns will be in the minutes, Chip, so at least we'd know we had the discussion about it and you've expressed your concerns. Dr. Esslinger: I think Ty's point is a good one too. I mean, prior to this there were no limits at all. If we wait for perfection it could take a long time and I think about this as baby steps toward a noble goal. Dep. Sec. Dunkle: Comments then? All those in favor say 'Aye' {Many 'Ayes' are heard} Dep. Sec. Dunkle: All those opposed?	

	{Silence} Dep. Sec. Dunkle: Ok. Dr. Larson: I'm sorry, I didn't get who seconded. I got that Dr. Adma was move… Dep. Sec. Dunkle: Second was… Dr. Larson: Ok. Dep. Sec. Dunkle: Somebody over here did. I'm hearing things. Dr. Adma: Holly did. Ms. Cobb: I did.	
II. Old Business B. Prior Authorization Criteria 3. Use of Stimulants and other ADHD Agents in Adults – Review proposed clinical criteria for adults prescribed stimulants and other ADHD agents.	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkle: So with that we'll move on to number 3, The *Use of Stimulants and other ADHD Agents in Adults*. Dr. Larson: Ok. So this is, again, was presented last time. And the changes are indicated on the document which includes removal of Strattera, Kapvay, and Intuniv. The other changes occurred that *one* of the following must be met. So, 'Patient must have a documented diagnosis within the previous 365 days of adult ADHD, binge eating disorder, hypersomnolence, depression in accordance with DSM-V or cancer related fatigue. OR Prescription must be written by a psychiatrist Patients with a documented substance abuse disorder within the previous 365 days will require a peer-to-peer consult with health plan psychiatrist, medical director, or pharmacy director for approval Length of approval: 12 Months' Dep. Sec. Dunkle: Committee comments.	Dr. Porter moved to accept the criteria as amended. Dr. Adma seconded the motion. The criteria were approved as amended unanimously.

	Dr. Ellermeier: With the diagnoses, I know we talked about this last time, but, do we feel like hypersomnolence covers narcoleptic patients? We're talking about 24 and older. Do we have to add narcolepsy? Dr. Porter: Yea, it's a separate diagnosis. Dr. Larson: Ok. Dr. Adma: So if somebody has been smoking pot, then they will not be able to bill for any of these prescriptions? In the last year? At any point of time? Dr. Porter: If they got the documented substance abuse diagnosis. Dr. Ellermeier: It would be a peer-to-peer. Dr. Larson: Which for that, in terms of the numbers, it was 182 individuals. Dr. Adma: Out of how many? Dr. Larson: We have 1,900 adults on these drugs, I believe, and there were 182 with SUD diagnosis. So, 10%. Dr. Porter: I'm sorry if I missed this; does this mean if you're 23 and younger, it's ok to party a little bit with your ADHD? Dr. Larson: No. Actually, all that is currently in place is for the 24 and older, it's something we could bring back to look at. But considering the use of adult, general age, out of school, we used the age 24 and older but we could change that. Dr. Millhuff: I will say, referencing our previous discussion about this format, they tend to break it out…well, they do break it out in age ranges of less than 3, 3 to 5, 6 to 12 , and 13 through 17, and then 18 begins adult. Dr. Larson: And the reason we went with the 24 on this one was to allow for those individuals still possibly in educational programs or whatnot. I don't know if there's any other, but it was more for	

	that age, because you could have some people over the age of 18 still utilizing these agents. But, again, we could change that to any age which the committee feels appropriate. Dr. Porter: This one is particularly about diagnosis by a non-psychiatrist and about substance use with your ADHD stimulants. Basically it's what we're trying… Dr. Adma: This is for the adults, Chip. It's not for the kids. Dr. Millhuff: Right. Dr. Porter: I would say, I guess I mentioned in a joking manner before, I don't think it's less of a problem to have a substance use disorder at 20 and use a stimulant than it is at 24. May be even more of a problem, given the brain is still maturing, etcetera. So I would say that if we go forward with this criteria I would think to knock the age down to something lower than that. It makes sense to me. 18. Dr. Adma: The other thing is, I know that in rural Kansas, psychiatric nurse practitioners sees some of these patients, and we're saying they have to be written by a psychiatrist. Dr. Porter: That's what threw me for a second. I over commented earlier on, because that would be in the cases that meet none of these criteria. Dr. Larson: So it's an 'or' situation. Dr. Porter: None of those diagnoses. Dr. Larson: So if you have a nurse practitioner and a diagnosis of ADHD, it would not hit the PA. Dr. Adma: Got it. Got it. Ms. Cobb: It would not? Dr. Larson: It would not. Or it could be written by a psychiatrist and then it would not, basically within the system, it would not search for a diagnosis.	

	Dr. Adma: So do you see a psychiatrist writing this for any other diagnosis though? Dr. Larson: I don't have the breakdown, but I do know on this one in particular, so out of the 1,900 that we had age 24 or older, we only had 1,073 with a diagnoses that matched here. So that left 824 that hitting the PA and then, of that, we only had 20% of the prescriptions for over 24 were written by psychiatrists. So that left 660 individuals to hit the PA edit. Dr. Porter: One problem we talked about before was the manner in which that was gathered. I don't know, a while back. Dr. Larson: We went back and took a look. And so that, this one, we have confidence in that we re-did it in terms of the diagnosis, now this won't include, actually, no, it does include narcolepsy, because you looked at narcolepsy with hypersomnolence. So it does include that diagnoses. That was what we looked at. We went back the previous 365 days and looked for that diagnoses from the date of the script. Dr. Porter: But how we get the diagnosis, we talked about last time, sometimes was from the billing. So an individual who was seen for depression and also their ADHD meds were refilled might show up, it's on the chart, hopefully, have ADHD, but the billing wouldn't have that on it. Dr. Larson: The billing. But it would look for any bill in the previous year that had that. So if they had never on any bill ever had one of these diagnoses, then it would hit the edit. Dr. Porter: In the past year? Dr. Larson: In the past year. Dr. Ellermeier: And even then, it's going to be like an automated PA. Where it's looking at systematically for the diagnosis, it doesn't find it; it kicks it out to a manual PA, right? And then at that point the doctor could provide the diagnosis. Is that correct? Dr. Smith: Correct.	

	Dr. Millhuff: And we talked about this last time, I believe, if you just have one diagnosis that you're billing under and comorbidity is the commonality with psychiatry, I mean, how do you pick up that ADHD diagnosis in your. Dr. Adma: With more than one diagnosis. Dr. Porter: That's what I'm talking about. Dr. Smith: We can capture 15 diagnoses per claim. So if you use more than one. Dr. Todd: On a medical claim? Dr. Smith: Yea, on a medical claim. Dr. Esslinger: And wouldn't bump it up against all claims looking for all diagnoses, correct? Dr. Larson: So even if you didn't on that particular encounter, diagnosis it, say you just saw them this time and you only put the primary as long as somewhere down the line in the previous year, you had indicated, or somebody indicated even as a second or a third or a fourth diagnoses, the ADHD, the system would be able to take a look at that. {Several speaking over each other} Dr. Porter: Some of that is maybe something that's an education piece and also maybe people's software. Because some of our, depending on what you use and how you bill it, may, some will allow you to put in one. I've worked in several different places, some want just one diagnosis, and the place I work now, easily add in all the diagnoses and they all go on the bill. So I think, I think the educational piece would be, 'guess what, from the MCOs standpoint, they like all the diagnoses. They want all the diagnoses you can fit into your system'. Dr. Esslinger: And that is why we're going to look at all diagnoses from multiple sources. Dr. Millhuff: You know, along these lines, is the question about the quality of the evaluation. Besides just seeing well, they've used it to bill for that appointment. When do you take a deeper dive to say let's look at the actual evaluation itself to see how thorough it was and if it didn't really	

	meet the criteria going back to childhood for ADHD. For instance, I'm thinking of the group that you brought up just a moment ago, Ty, in terms of college age students that really don't meet full criteria for ADHD. I'm just; this is kind of a kind of a practice issue. Dr. Esslinger: Yea, it's a problem. Most of our data comes from claims and you're not going to capture that in claims, at least not today. There are some technologies that are looking at extracting data points from narratives insurance, which is kind of exciting. Hedis measures, anyway, but today, I think, that would require a manual review to get at the quality of evaluations. Dr. Ellermeier: I think, short of actually making the criteria be the diagnostic criteria, I can see that being problematic. Dr. Porter: Probably, I guess this is getting left field again, but again, putting in the comorbidities that are important, not just filling it with everything, will also, at some level, will give credit if you need to spend a longer time with your appointment. It's going to be a more complex case. Or if you're having to see somebody more frequently, they're not getting well as fast. Some of these things, I guess there's going to be more quality assessment of our work the federal and other programs, it's probably good for us to start adding those extra diagnoses which would help some with the things you've brought up today; catching ADHD when we're seeing them for depression. Dep. Sec. Dunkle: Any other comments on? Do we have a motion to accept or to approve? Dr. Ellermeier: Didn't we change it to 18? Dr. Larson: I just want to go through what I have here as the changes. So I have changing it to adult age 18 and older and the addition of narcolepsy. Dr. Todd: Liane, there's an age right down here too. Dr. Larson: Thank you. Dr. Todd: Just trying to catch all the pieces. Dr. Larson: I appreciate that.	

	Dr. Todd: Sure. Dr. Porter: Do people think, this is something, I guess the other prescribers here especially, 365, there's different levels of substance use disorders, do we think that's reasonable? That somebody, for example, did have a, that somebody had smoked some weed, that they had a positive drug screening from weed, that they are now 365 from taking a stimulant at least having it paid for by Medicaid? Do you guys think that's a good criteria? Dr. Larson: It would come up with the PA, but that's where it comes in for a peer-to-peer consult. Dr. Porter: Understand, yea. Dr. Larson: But, again, can change it to whatever the committee feels is appropriate. Dr. Shoyinka: I think you'd want to flip that question around and ask yourself is it really; is he just trying a little pot? Does that allow for an accurate evaluation? Dr. Porter: Yea, I'm not saying I totally disagree; it's just something that wasn't part of my training. I think we kind of figure it out as we go. And I didn't know if everybody was…I traditionally had set a lesser clean goal than the year before I would consider it. Dr. Todd: Is it 180 days or something? Dr. Porter: I hate to be the one answering the question. Dr. Adma: Where'd you get that from, the 365 days? Dr. Larson: I think… Dr. Adma: Is there any evidence base for that? Dr. Larson: No. It was just going with having the diagnoses and substance use. There might have been, and I'm sorry, because we brought this criteria last time, so it's probably been 4 or 5 months since I developed, it could have been that I was looking at other states, having that be the criteria there with the common one year. I couldn't say specifically where it came from.	

	Dr. Shoyinka: And also under DSM-IV for the criteria for remission, full remission, was a year of sobriety. So that's a useful rule of thumb as well. Dr. Mack: Well, and if it was a case of somebody using one or two times of cannabis, it's probably going to be a very short consultation with the plan psychiatrist to reach the approval in a case like that, I would guess. Dr. Porter: I'm not even sure, depending on the clinician, if that meets the threshold for a use disorder. I hadn't actually thought about that. Dr. Mack: Exactly. I think that would be a fairly brief conversation if it were a case like that. Dr. Porter: Ok. Ms. Cobb: Maybe it's Cancer related? What we're prescribing it for, you know. Dr. Shoyinka: Mind you people smoke pot for cancer they don't smoke…not to complicate this. Ms Cobb: That's what I was saying. Dr. Porter: That's why we have, that particular issue is why we have people in veteran's hospitals that are terminal cancer who are taken off their pain meds because they tested positive drug screen. Sorry, you know that the swing back has gotten a little extreme in some individuals' cases. Dr. Millhuff: Why is Strattera not on this? Dr. Porter: Because it's not controlled. Dr. Shoyinka: Additional stimulant. Dr. Larson: That was, I did originally have it on the list, and per the committee, the last time wanted to take it off.	

	Dr. Millhuff: But it says 'Use of Stimulants and other ADHD Agents', and in the context of this discussion with our clients that have substance use problems, Strattera is a nice option. Dr. Smith: It stays wide open. If it's not on the criteria; open access. Dr. Porter: We took all the non-stimulants off of here for that reason. Dr. Millhuff: So there's no monitoring of it. Dr. Porter: They don't have to be clean for a certain amount of time to have their ADHD treated with non controlled substances. From preferred drug, it's a choice. You know, I think I brought up the pause in this, I'm fine with the 365, I don't have a strong feeling, I just put it out there to see what other people thought. Dr. Millhuff: I just think for the practitioner out there that's reading these criteria, and just like I just said 'Well, what about Strattera; it's not on the list; is it not approved?' I mean, could we put an asterisk on there or something, I don't know, just something to guide the people that need to learn about this? You know, this is set as 'Use of Stimulants and other ADHD medicines Agents for Adults 18 and over. Dr. Larson: And then it says 'The following drugs require prior authorization', so you're seeing where it's stricken through, I'm just leaving that on there for informational purposes today. But it won't be on there, so it wouldn't be included as a drug that requires prior authorization. Dr. Porter: We could also just eliminate 'and other' from the title. Dr. Larson: Ok. So you want: 'Use of stimulants'? Dr. Porter: Yea. I'm not saying we shouldn't add another asterisk to remind people there's non-stimulants but that would at least make it consistent. Dr. Larson: So you just want: 'Use of Stimulants in Adults Age 18 and Older'? Dr. Esslinger: Or you could say 'Use of these Stimulant Medications'.	

	Dr. Todd: Or a note at the bottom that the non stimulants do not apply to this criteria; this criteria does not apply to the non stimulants. Dr. Larson: I have a couple different things. So you want 'Use of Stimulant Medications'? Dr. Todd: You know, at the bottom. Dr. Millhuff: I like what she just said. Dr. Todd: So that if somebody glances at it. Dr. Millhuff: The person that's trying to orient to this; 'why isn't adult Strattera, where is that in this, does it exists somewhere, am I missing something here, am I going to get surprised' Dr. Todd: Because it's real common, like for DUR, we'll include notes that are trying to be a little more helpful. Dr. Larson: So I have here written: 'Non Stimulant ADHD medications are not included in this criteria'. So then I will also remove it from, 'Criteria for Stimulant medications prescribed to adults age 18 or older' Dr. Millhuff: That's good. Thank you. Dr. Todd: Does that help, or would you need to have those specific drugs, like, for example, or such as, you know what I mean. Dr. Millhuff: Besides Strattera, what else would we be talking about? Dr. Porter: Kapvay. Dr. Ellermeier: Kapvay and Intuniv. Dr. Millhuff: Kapvay, Intuniv and Strattera, I know there's other ones that are used. Dr. Porter: Not approved, Bupropion is used but I don't think it's FDA approved. It wouldn't apply.	

	Dep. Sec. Dunkle: Alright then, as amended, I would entertain a motion if someone has one. Dr. Porter: So moved. Dep. Sec. Dunkle: Motion by Dr. Porter. Second? Dr. Adma: I do. Dep. Sec. Dunkle: Second by Dr. Adma. All those in favor, please say 'Aye'. {Many 'Ayes' are heard} Dep. Sec. Dunkle: All those opposed; same sign. {Silence} Dep. Sec. Dunkle: Thank you.	
II. Old Business B. Prior Authorization Criteria 4. Use of Stimulants and other ADHD agents in children – Review proposed clinical criteria for children prescribed stimulants and other ADHD agents.	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkle: Ok. *Use of Stimulants and other ADHD agents in children.* Dr. Larson: So the Use of Stimulants and other ADHD agents in children ages 3 or younger with the changes that were made are indicated with the red. So now it reads: Criteria for stimulants and other ADHD medications prescribed to children ages 3 and under: Must be prescribed by or in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician. What was removed was the peer-to-peer consult. So it would just be that one simple criteria of who is prescribing for those under age 3. Sorry, 3 and under. Dr. Millhuff: So the preschool ADHD treatment study had for Methylphenidate, ages 3 through 5, and so I think the numbers should be not 3 and above, I think it should be less than 3 and that's consistent with the other parameters I show on this Texas algorithm. Dr. Larson: Was that specific for that one medication or for all medications for under 3?	Dr. Ellermeier moved to approve the criteria as written. Dr. Adma seconded the motion. The criteria were approved unanimously.

	Dr. Millhuff: Let's see here; I know this for Methylphenidate, it's just general Methylphenidate. Dr. Adma: So is that less than 3 meaning 2 years? Is that what you're saying? {Several people speaking at the same time} Dr. Ellermeier: Asking that it's prescribed in consultation with a specialist for a 3 year old I don't think is unreasonable. Dr. Porter: There were 33? Dr. Larson: There were 33 members identified. I don't know how many of those were prescribed by one of these indicated prescribers. But, then it would be, say for instance all those 33 were all prescribed by a child or adolescent psychiatrist, pediatric neurologist, or developmental-behavioral pediatrician, then none of them would hit the edit. It's just solely indicating who would be prescribing these medications. Dr. Murff: Liane, I have a question, and this would not apply to mid-level prescribers, is that correct?. Dr. Larson: No, well, it could be in terms of where that 'in consultation/collaboration' wording comes in. It would be a mid level if they worked in consultation/collaboration with a child and adolescent psychiatrist, pediatric neurologist, etcetera. Dr. Porter: The family practice doctor in Philipsburg who gets his patient back from the hospital and he's supposed to keep them on their meds, that'd be maybe one of these. What would be the, back to that, what would be the way he would communicate that? That would be something we'd want to make sure what kind of documentation he'd need, who would he send it to, etcetera. I know I brought it earlier. Dr. Smith: Sure. So like on the PA form, when he's saying he is continuing medication that was started at KVC by, you know, Dr. Adma, that would be in consultation with, he's not initiating the dose, he's just continuing it and it was started by a child psychiatrist.	

	Ms. Cobb: That note would be sufficient? Dr. Smith: What's that? Ms. Cobb: That note would be sufficient to continue it? Dr. Smith: Our reviewers would accept that. Dr. Adma: Recently we had a 3 year old, in our outpatient clinic, our outpatient clinic only has a psychiatric nurse practitioner, so we brought in the child psychiatrist to see the patient for the first time, but we had, now we have a system where the nurse practitioner sees them for one time and then the child psychiatrist sees them, so they alternate. So in this system would that work? Or they could not work because they have to be seen, I guess, in consultation would be fine. You have the child with the Nurse Practitioner in there, right, in consultation with this. Dr. Porter: NPs would be the easiest because by law they have a consulting license. {People talking over each other} Dr. Adma: A NP can actually see a 3 year old and they have the collaboration. Dr. Smith: For this one it probably won't apply. In other cases it would, but in this case, since it stops at 3, if they're 2 years old, you would've had to get the PA anyway. When they left KVC to get it filled and by the time it needed to be renewed 12 months later, they're going to be 3 and it's not going to have a PA anymore. But I think you were thinking conceptionally, then this particular criteria. Ms. Cobb: But any adjusting of doses it wouldn't have to. Dr. Smith: Correct. It would only be if they changed the drug. So if they are just increasing the dose of the same drug, it wouldn't hit, but if you change drugs, then it would hit the PA again. Dr. Adma: The other concern is there are some psychiatrists who primarily see only children; they see a majority of children. Here it's specific about child and adolescent psychiatrists. So what if there is a general adult psychiatrist but they're seeing a majority of children?	

	Dr. Larson: We actually had, I wrote the criteria to indicate just general psychiatrists, but then committee wanted it changed specifically to child and adolescent psychiatrist. Dr. Esslinger: Because of the real young age? Dr. Larson: Yes, because of the really young age. Dr. Millhuff: You kind of run into let's say there's a pediatrician that's a specialist, can demonstrate 'I've had specialty training in this area' how do we kind of build that into this, something that happens, people can maybe submit something, that say I we all know it that doctor so and so has a lot of experience in this, maybe to start out, kind of like you were saying earlier, at least get this first tier through with specialists and then. Dr. Esslinger: I'll be an uncommon situation, right? Dr. Adma: What's that? Dr. Esslinger: It's going to be an uncommon situation. Dr. Adma: It's uncommon, it's not common. Dr. Esslinger: Right. So I think once we become aware, it's authorized. So they will call the first time and it should be good for a long time. Dr. Murff: Did you have numbers for this one? Dr. Larson: 33 total. Dr. Esslinger: But this is specifically about an adult psychiatrist prescribing for kids almost exclusively. So my point was it was so uncommon and they have to call in for that, it's not an earth shaking thing because it's not going to happen that often. Dr. Adma: So 33. Was that, psychiatrists, child and adolescent psychiatrists, a combination?	

	Dr. Larson: I don't have any data. Dr. Porter: The other thing is we did take away, I'm sure we talked about it, we took away the opportunity to get the prior approval on this. If you were outside of the criteria, it just says, can't. Dr. Larson: Well it was basically, that it was to be prescribed by those individuals and then to have the peer-to-peer consult. This is taking away that extra step. So from the discussion last time it was the committee was saying we felt for children ages 3 years and younger, it really should be prescribed by these people. These specific prescribers for child and adolescents, but they do not need to do the peer-to-peer. Dr. Porter: This individual we just talked about. Dr. Larson: It would have to be on basically a process with the MCO. Dr. Millhuff: The other thing that I and we were just talking about the age range here, 3 and below, we were talking about the preschoolers, I'm trying to remember, we already approved something for preschoolers? Dr. Larson: No, not for ADHD all we've done so far are the two we've done today, the dosing limits and adults. This is the first one we've had for any children. Dr. Ellermeier: Do you know what the number would be for like 4 and 5 year olds? I can't imagine that we would have much different criteria other than a specialty consult of some sort. But I don't know what number to. Dr. Larson: From data, I think it had grown quite a bit in terms of the number, yes, with 33 at 3 years and younger, if my memory serves me correct, I don't know if you remember from looking at data, for ADHD meds in children, I just didn't bring it with me, I apologize, we do have it for 4 and 5 year olds, and it grew… Dr. Smith: Dramatically. Dr. Larson: It dramatically increased.	

	Dr. Smith: Which is in some cases that's, you know, as opposed to an anti-psychotic, that's your other treatment option and it's much better. Dr. Millhuff: The other thing here is the importance of having a behavioral intervention tried before these medicines. I think that needs to be part of our criteria. So and I think we need to specify training or care givers in an evidence based treatment format. This isn't just taking the preschooler into an office and having a one-to-one play session. It's something that would emphasis, you know, which is the standard of care with working with preschoolers, is to do training and that that would be something that's not a onetime intake visit. We've had 6 to 8 sessions. Dr. Esslinger: And anything like that I'd say It's very challenging, because we live in a world of claims unfortunately, unless there is a claim for those sorts of things, we wouldn't be able to capture it, so we wouldn't be able to determine if that is or is not done prior to the meds. Dr. Millhuff: Could you see that they've had therapy? Dr. Smith: We could do a provider attestation. You know, I've done this with this member. Like we talked about earlier. {People talking over each other} Dr. Millhuff: Well it would be behavioral modification kind of interventions. We keep hearing sort of labels like trauma informed, psychotherapy, the bottom line is there is sort of a psycho social intervention prior to starting the medicine. Dr. Shoyinka: I agree. Dr. Millhuff: And it's not just a one or two time meeting, I do a lot of preschool psychiatry and this is a serious issue, I insist that it take place before we are even going to begin to talk about medications. Dr. Esslinger: I think it's fantastic and it's a matter of, you know, clinicians documenting something. That we can hopefully have a checklist to patient has done A. B. C., and they can check yes/no, yes/no, yes/no. It wouldn't be unlike some of our criteria for bariatric surgery for example. Has the patient undergone nutritional counseling prior to this consideration? Has the patient	

	attempted and failed with a rigorous weight loss program? And there's two or three checklists. And so when the physician sends in the request for bariatric surgery, they're attesting, as Jonalan was saying, that these things have been done. So if there's three or four critical things people should be doing, we would do it by attestation. Ms. Cobb: It seems, especially in this population too, it's a really important population to make sure that's done. Dr. Millhuff: It's also that they've had a decent evaluation too, because I've already heard that's already hard to kind of determine from your standpoint, but this is something that primary care doctors face and they're being pressed to get this really wild kid under control but there's limited resources with people that know how to do this. Dr. Porter: Your thought would be, Chip, just the qualification of the individuals listed here. You'd still be concerned that maybe that they would neglect some of these important steps even these people with these qualifications. Dr. Millhuff: Yes. How are we going to pick out the bad actors, so to speak? You know I know that by raising this, I'm making it more difficult for myself; I don't want to go through a PA process with this. Dr. Esslinger: Well and this is a unique age group too. That's part of this thing. Would you do that for all of them or just this age group in particular? Dr. Millhuff: All of them being? Dr. Esslinger: Other age groups. Dr. Millhuff: Well, I'm, this specifies 3 and below, I really think it should be 5 and below. We're talking about preschool age kids. While the numbers go up when you get to 4 an 5 and I think without a doubt and child under 3, I'm really skeptical about using any psychotropic medicine. Unless it's a, you know, a really terrible situation, that is unbearable; severely autistic child or something that someone that has had terrible trauma. I didn't mean to complicate this. Dr. Adma: So the number on this again is 33 patients?	

	Dr. Larson: For 3 and under is 33. Dr. Adma: 33 patients for the whole state. Dr. Larson: For the whole state of Medicaid across all MCOs. Dr. Shoyinka: Are you suggesting that all kids under 3 perhaps not under 5, but certainly under 3, should get a PA if they want to start these medications except for the provider categories that are listed here? Dr. Millhuff: I agree. Dr. Shoyinka: Makes sense to me. Dr. Porter: Did you mean that? Dr. Millhuff: What? Dr. Porter: Except for…oh I get you. They would need a PA. Dr. Shoyinka: Except if they were in the… Dr. Porter: But you're suggesting steps put in place even for these people listed here, for child psychiatrist, and pediatric neurologist. Dr. Ellermeier: So attestation of prior attempt of non-stimulant… Dr. Millhuff: I guess what I'm trying to understand is how we can have safeguards to know that there is something in place. Besides just a PA process, do we have a component to what we're trying to do? Where it comes up on your radar and the case needs to be reviewed. It doesn't need necessarily to be stopped at the pharmacy but it's coming up for review, the doctor you've had a couple of these people and you look and see there's no claims for psychotherapy and at that point it's an opportunity, you know, we've got these…maybe what it is, is a recommendation in here, it's not so much a check and attest this is done, but it's in the spirit of educating people, letting people	

	know that this is something we're watching. That it is recommended that the child have a therapy before starting this. It's not so much, yes I have to attest because if it's only child psychiatrist, maybe that… it's not going to be, pass it anyways. Dr. Adma: So what this will do, Chip, I think is, if there are any 3 or under and there are 33 patients. For those 33 patients, there needs to be some level of consultation with a child psychiatrist, developmental pediatrician or that specialist, is what they're saying. So I think it makes sense. My only concern is in the rural Kansas were there's no child psychologist. Dr. Shoyinka: Actually, you're making a point. Those are exactly the kids that should not be put on these meds. Dr. Adma: Then in the rural Kansas, so, what this will do this will push those rural PCPs, other psychiatrists who are treating these 2 and half-3 year olds, to say 'hey, I think you need to go see a child psychiatrist. Dr. Porter: You know, I think there's a lot of great things about country living but one of them is not access to specialists. So I think that these 2 year olds should go to a center and see somebody that's been trained in this. Dr. Adma: So this will do that. So they might make a long trip, at least the first time, and then come to you and you get to see them, stabilize them, whatever, and you push it back and they would be in consultation with. So I think clinically it makes sense in it a safe thing to do. I think what you are also suggesting is, could we add a behavioral intervention piece to it, right? Dr. Millhuff: Right. Dr. Adma: Because you're now prescribing medications to a 3 year old, right? Ms. Cobb: And if the PCP or physician, or whoever it is, knew this information was out there and in place it might take some of that burden off them to know that process, if that information can be disseminated. Dr. Adma: To give those PCPs in rural areas the tools to tell the parents that hey, they need to go see a specialist.	

	Dr. Millhuff: Vishal, we did, our agency does, a consultation with nurse practitioners out in rural settings. This has come up as an example and so that nurse practitioners can say, yes, I've made this decision in consultation with a child psychiatrist. Dr. Adma: Yes, yes. Dr. Millhuff: I guess I'm wondering if, in our criteria, there's room for just making some, stating, some recommendations at all. This is not so much, you know that we're not going to make it a PA issue but so that it builds in any kind of educational information with this. Can we do that? Dr. Ellermeier: What if it is an attestation of a non psycho pharmacological intervention or reason that has not taken place. Say 'yea, we did it' or 'we thought about it, but this why we couldn't do it or didn't do it', maybe. So that serves as an education piece because you are having them write something on a form, but it's not a hard, like, 'no' if you didn't do this you can't have it, just that you thought about it. Dep. Sec. Dunkle: My next question is what do you do with that? It's one thing to have somebody put, to take time and put it on paper, but if it's not part of the criteria and it's really not part of something the MCOs would necessarily need to collect. Dr. Ellermeier: I'm saying is, proposing to make it a bullet point of the criteria that they have to have attempted non-pharmaco logic intervention or there's a reason why they did not attempt that. Dr. Porter: We actually have that as criteria for some of the other. That's the criteria I mentioned earlier on the monitoring cases. Dr. Millhuff: It's kind of like, you have a very aggressive child in your office and you're not going to get lab work done on this kid. The criteria, does it make any kind of, sort of, exception for that? I guess you've got to go through a PA to do that, but if you've got an acute situation like that day, that afternoon. Dep. Sec. Dunkle: So I guess the question is then, is it a PA criteria or not? If it's a PA criteria, then yea, I think you put a form out there and you say 'yea, we did an intervention and here's what it	

	was' or 'we didn't do an intervention and here's the reason'. If it's not part of the PA criteria, why we would collect that from an administrative side is beyond. Dr. Esslinger: I applaud the discussion around trying to put some rational behind ADHD treatment especially young children. I think PA, in a sense, is a bit of a blunt instrument. I think that it's really putting some wide guardrails on what we're talking about here. I think to really get at that it's really going to require a more substantial educational effort. There's some element of education here because we're talking about dose limits and such, but when you get into all the facets of what should be done, for example, prior to ADHD treatment, I kind of feel it's like beyond the scope of this particular thing. Unlike the bariatric surgery example I gave, they have to provide clinical note evidence that those things occurred, I don't know what you would be suggesting for the things that should be done, I don't know if those are capturable, documentable, or simply taking the practitioners word for it 'yes, I did that, that, and that'. So, to me, I think, I would just go with the blunt instrument here and look for other avenues to educate physicians about proper diagnosis and treatment of ADHD. Just for your consideration. Dep. Sec. Dunkle: It's not that I think it's a bad idea having that kind of conversation. It's just, within this tool, unless it's actually part of the PA criteria; I'm not sure what the value is. I think the education component, yes; it's valuable, but probably in a different… Dr. Millhuff: What I'm reading by studying the program in Texas is that their review, when it comes up that the practitioner is outside of the parameters, it doesn't necessarily stop the treatment at the pharmacy. It triggers a review, a treatment review. Then, that, you know, it's not like there's an abrupt change in terms of when a prescription can be filled, it brings to the attention the treatment, the practicing methods of the prescriber. Then in the discussion, obviously, if what they're doing is not making sense, then at that point the psychiatrist reviewer 'says this is not something I can approve, we need to shift another direction from what you're doing here.' Dr. Esslinger: I wonder if that's a State program or something. In other words, who is the psychiatrist that is working on the behalf of? That's reviewing that. Dr. Millhuff: The universities and their specialty centers. Which is something, I think, would help us to do what we're trying to do here. To make the emphasis of what our committee is doing is more on a, have more of an educational component and change prescribing practices.	

	Dr. Esslinger: That's a great idea. I just think it's a bit outside the scope of this. Dep. Sec. Dunkle: I think that going down the direction of what we could provide as education is something we probably need to talk about on a future agenda. We talked about it before. Unfortunately this agenda, we're trying to get through all of our mandates from the legislature. But I think by the time we get to the next agenda, we'll a little bit more leeway on being able to have some of those conversations. Suggestions, things we might ask the MCOs to do, things the MCOs might ask the State to do around those issues of education and provider prescribing. Dr. Millhuff: I'm bringing it to the table because of what I've seen in Colorado and other states that are doing more of this kind of a method. We had the gentleman that presented to us at the end of our meeting last time talking about just purely this kind of process, having its flaws. In terms of, I don't want to get off track here now. Dep. Sec. Dunkle: So from the conversation, what we have, really there's been no change to the policy as far as a formal change to this. I guess at this time, I'd entertain a motion for approval if anyone is so moved. Dr. Ellermeier: Motion for approval. Dep. Sec. Dunkle: Motion-Ellermeier. Dr. Adma: I second it. Dep. Sec. Dunkle: Second by Dr. Adma. All those in favor please say 'aye'. {Many 'Ayes' are heard} Dep. Sec. Dunkle: All those opposed; same sign. {Silence}	
III. New Business	**Clinical Public Comment: -** No requests were received. **Board Discussion:**	Dr. Porter made the motion to approve as written.

A. Prior Authorization Criteria 1. Use of Multiple Concurrent Tricyclic Antidepressants (TCAs) – Review proposed clinical criteria for patients prescribed multiple tricyclic antidepressants.	Dep. Sec. Dunkle: Because it is our way, it's 4:10, we're gone overtime already a little bit. I know State staff will stay here as long as I tell them to, so. Dr. Smith: And the MCOs as well. Dep. Sec. Dunkle: And the MCOs probably will too. Dr. Larson: The doors are locked at 5. Dep. Sec. Dunkle: Yea, the doors are locked at 5. Is everybody on the committee ok with moving forward with the agenda? Dr. Adma: Yea. Dep. Sec. Dunkle: If anybody has a hard stop, let me know when it gets close. Dr. Millhuff: 4:30. Dep. Sec. Dunkle: 4:30? Ok, we'll plan on going to 4:30, because if Chip has to leave, then we don't have quorum and we can't do anything anyway, so. Now we'll move on to new business, *Prior Authorization Criteria, Use of Multiple Concurrent Tricyclic Antidepressants*. Dr. Larson: So this is being brought to the committee at the committees… Dep. Sec. Dunkle: Real quick before we get into it. Just a reminder, anything we do in the way of adjustments, amendments, changes to this will come back to the next committee for additional conversation/approval like we did the 3 today. So this is by no means a final action on any of these. This is really discussion, suggested edits, and amendments. Or just kill it and just say 'no'. Dr. Larson: This was brought in to; the committee had asked when we were doing the multiple concurrent SNRIs/SSRIs and asked specifically about TCAs. So this is brought to you, a proposal, here you can see I indicated most of the TCAs, however I did highlight the ones that committee removed from the overall anti-depressant category, I don't know if you remember that, but when I brought all anti-depressants; the highlighted ones were removed. So I did put them on here, I didn't know if the committee would want to remove them from a TCA policy or want them included. So	Dr. Ellermeier seconded the motion. The criteria were approved as written unanimously.

	that's where the breakdown is. Otherwise, the criteria is exactly the same as what was passed through for SNRIs and SSRIs. So it would be two or more different TCAs used concurrently for greater than 60 days would require a prior authorization, which would be a peer-to-peer consult. Dr. Porter: I'm just curious; this would seem like a low number item. Dr. Larson: I actually did not pull information yet on these, since we'll be bringing everything it back. Otherwise, I'm pulling data now and then changing it again. So I don't have on this particular one. I would echo that and probably say it's a very low number. Dr. Porter: I'm going to try something. I move to accept these. Dr. Ellermeier: I second. Dr. Larson: And is that with the highlighted ones or without? Dr. Porter: With. Dr. Larson: With the highlighted ones, ok. Dr. Adma: Quick question. Was there a reason why we decided these highlighted ones to be taken out? Dr. Porter: This came from DUR. Dr. Larson: No, this was from the committee here. Dr. Porter: I don't know why but I know we wanted Doxepin, Amitriptyline, and, of course it's not technically, I guess, on this Tricyclic list, Trazadone, because they are commonly used as hypnotic and pain agents. I'm not sure why, I know Imipramine used sometimes when you research, I'm not, I don't remember the reason about Imipramine or Nortriptyline. Dr. Ellermeier: Was it because they have other uses, basically?	

	Dr. Porter: I know Imipramine is used in research. I don't know about Nortriptyline. I don't remember that part of it. Dr. Adma: Again, what are the numbers like for this? Dr. Larson: I don't have it for this one just because bringing it for the first round of discussion, I did not pull. Ms. Cobb: They have quite a few uses other than TCAs, but I still think it's, you should have two or more. Dr. Adma: Is this something that you can bring back with additional information as to why we highlighted those? Dr. Larson: In terms as to why they were removed before? Dr. Ellermeier: It's the, if I remember correctly, it's the anti-depressants and those 2 or more or Dr. Larson: 3 or more. Dr. Ellermeier: 3 or more of any class of anti-depressants we thought the use had multiple indications, multiple uses. Dr. Larson: That's it exactly. Yes. Ms. Cobb: Ok, so if you had a SSRI and Amitriptyline, with that there's some catch? Dr. Larson: Yes, and then they were removed from that list. Ms. Cobb: So that's what we were thinking. Dr. Adma: Ok, now it makes sense. Dep. Sec. Dunkle: We have a motion and a second, all those in favor?	

	{Many 'Ayes' can be heard} Dep. Sec. Dunkle: All those opposed? {Silence} Dep. Sec. Dunkle: Alright. We'll bring it back next time with no edits on it.	
III. New Business A. Prior Authorization Criteria 2. Use of Multiple Concurrent Mood Stabilizers– Review proposed clinical criteria for patients prescribed multiple mood stabilizers.	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dr. Ellermeier: Is that a first? Dep. Sec. Dunkle: I think it might be. Dr. Larson: The benzo one. Dep. Sec. Dunkle: The benzo one, then we ended up changing it. No we didn't change it. On to Number 2; *Use of Multiple Concurrent Mood Stabilizers.* Dr. Larson: This was brought to the committee; this is our last class of drugs to review, just in a general review format. It's being brought for consideration as a starting point. For the proposed criteria for mood stabilizers: Three or more different mood stabilizers used concurrently for greater than 60 days will require a prior authorization: At least one medication must be prescribed by or in consultation/collaboration with a neurologist and then the Patient must have a documented seizure related diagnosis within the previous 365 days. That would be to acquire 3 or more mood stabilizers. Dr. Ellermeier: So, they could be on 2? Dr. Larson: They could be on 2, correct. Dr. Porter: Lithium's kind of the odd man out here. I don't know why, it's not an anticonvulsant at all. In fact it would make it more likely to have a convulsion. Dr. Larson: But then it'd be, basically, Lithium would be used because it's in combination with the others.	The criteria were tabled to the next MHMAC meeting.

	Dr. Adma: Somebody can be on Depakote, Lithium, and Lamictal? Dr. Porter: Yea, it would hit with that combination. Did you have numbers on that one? Dr. Larson: On this one, I have some rough numbers. Out of 7,800 members on mood stabilizers, 34 members would hit the edit as currently written. Dr. Ellermeier: So the outliers. Dr. Adma: Of those 34, you don't know how many have seizures? They wouldn't hit that, right? Dr. Larson: No. I wouldn't have that. Upon further review it would reduce the number if there were those indicated with seizures, correct. It was just the, kind of, with the starting point in which those patients would be reviewed to see if they meet the criteria or not. Dr. Adma: So these could be psychiatrists or neurologist, right, prescribing these? Because if somebody has epilepsy. It's common that they can be on 3 of these medications. Dr. Larson: So, are you wanting to change it to have 'in consultation/collaboration with'. So we did have it where that at least one medication must be in consultation/collaboration with a neurologist. Dr. Adma: I know, but if I'm a practicing neurologist. Dr. Larson: Yes. Dr. Adma: Would it still hit the pre authorization process if I'm, I'm not a psychiatrist, I'm a neurologist? Dr. Smith: This one would. Dr. Larson: This one would. Dr. Adma: That might be a problem.	

	Dr. Ellermeier: 34 patients. Dr. Adma: Because your systems don't talk, right? So they already have a seizure diagnosis. Dr. Smith: They'd have to say neurologist, that they have a seizure diagnosis. Dr. Adma: It's a lot of paperwork for us. Dr. Ellermeier: 34 people. Dr. Porter: Again, that gets back to the whole idea of how you do prior auth. That neurologist happens to reach the plan psychiatrist for a peer-to-peer and doesn't say that versus send in a form that says I'm a neurologist, I just hope that we continue to have a dialogue on how we do prior auths and the phone tag between the clinician and the busy MCO psychiatrist takes up a lot of time. I hope we can look to opportunities to try. A lot of the companies; you guys aren't inventing prior auths, we've seen them before. The vast majority of them don't start out with a peer-to-peer. They generally, you have some ability to document some criteria, you send it in and see what happens and the peer-to-peer is saved for the purpose of a denial. This is like a time to do an appeal. I heard that that's not really under our committee's perusal to dictate that, but I'm appealing that we consider paper prior to phone call. Dr. Esslinger: Well, let me ask the pharmacists because you're tied to the operations. So at least one medication prescribed by a neurologist, so, the claims information we have, and we'd know, if that prescriber was a neurologist, right? Dr. Porter: Doesn't sound convincing. {Several people talking at the same time.} Dr. Esslinger: I'm trying to answer Ty's question. And I'm trying to determine how easy or hard it is for us to determine whether or not there's a prescription, in one of our systems, that the prescriber was a neurologist. Dr. Murff: Are we talking about if knowing if it was prescribed in consultation as in automated?	

	Dr. Esslinger: No, just prescribed by the neurologist. Dr. Murff: You're talking about the prescriber in the claim knowing that he's a neurologist. Dr. Esslinger: I'm a family doctor; I'm prescribing this particular medication. I've consulted a neurologist. Dr. Smith: We can't get their MPIs. Dep. Sec. Dunkle: If we can't do that, we can't tie it to psychiatrists or anything else either. So we're kind of having a hard time. Dr. Smith: It's a separate build to look at different provider types. So every provider type we add would be an additional build for us. I guess. So, we are already going to be doing it for psychiatrists, that'll be done. We'll have to add it for neurologist if we want to automate it. Dr. Porter: Because triple therapy is fairly common. Maybe not with, there's only 34 Medicaid, but it's not unheard of. And they're almost all by neurologist. Dr. Adma: As well as if you can tie it, earlier we talked about tying it to a diagnosis, so if it's in there builds if seizure disorder, epilepsy is listed, it shouldn't go to the prior auth process. Dr. Ellermeier: So you would omit the specialty then, if they have the diagnosis in their system? Dr. Adma: So, yea. If they have the diagnosis, like earlier we talked about. Dr. Ellermeier: So it's an *or*. So, prescribed by or in consultation/collaboration with a neurologist *or* must have a seizure disorder. Dr. Smith: I like that actually. Dr. Esslinger: Well that's one fact. One other thing I think you're hearing is operationally, when we start to make criteria dependent upon a specialist seeing the patient or having history of the patient, it's problematic from the operational side. So, one thing just to throw out to see what you guys think, because you're closer to it than I am, would this be something, because it's not a psychiatrist,	

	we're already building that one, an attestation. It'd be still true to what you are trying to do here. It would be relatively easy for the requesting person trying to get the PA to say 'yes, this patient has been seen by a neurologist'. Dr. Ellermeier: I think that's the only way to do it if you're asking for consultation is through an attestation. Dr. Adma: All I'm saying is, attestation is fine but is there a way to work around that attestation? That'd be one step less. Dr. Smith: Sure. We can build a SMART edit. Dr. Todd: So the SMART edit would be, the idea of the incoming claim, that third claim of the concurrent, right, it would come in the claim system itself could look. We load like all the diagnoses from medical claims, so the pharmacy claim system looks at those, finds the diagnosis, and then it'll also say oh, this MPI belongs to a neurologist, we're just going to go ahead and pay this, no one will even know, it'll be seamless, no one will even know there's a PA criteria around it, right? If it isn't a neurologist, that's when it would do a hard stop and it would require a PA and then someone would have to turn in a form and then you could have the check box of 'yes' and then 'in consultation with'. Dr. Adma: Ok. Dr. Larson: So the changes I've made, so it would be: Three or more different mood stabilizers used concurrently for greater than 60 days will require a prior authorization: (must meet one of the following) at least one medication must be prescribed by or in consultation/collaboration with a neurologist or patient must have a documented seizure related diagnosis within the previous 365 days. Does that meet the intent of the group? Dr. Murff: So, I mean, yea, I'm just thinking from an operational standpoint, if you could do that. I think you could do diagnosis with specialty and it would go through, but I don't know if you could do 3 of them, and only one of them have that requirement. Do you see what I'm saying?	

	Dr. Todd: It would go through if the third claim was the neurologist. It would go straight through. But if it isn't the neurologist, it would be a hard stop and take a look. Dr. Murff: This is what makes me nervous about having PAs. Dr. Esslinger: Keep in mind; it's an operational challenge to build something versus 34 patients. Dep. Sec. Dunkle: Yea, I think this is one to stop and look in your guys' part is probably a lot easier than building out. As long as we have it in the policy and the understanding with the operational, with the contract with the MCOs like, here's things you don't put the hard stuff on the prior authorization until you've actually gone in to look to see if they meet the criteria. Dr. Porter: On this one, the other thing that's not quite clear would be, we're saying if you have these three things you need a prior, will require prior authorization and then it goes on to say two things. But it doesn't say if there's a way…like it doesn't say unless, needs a prior authorization unless one of these bullet points is met. Dr. Ellermeier: I think that's the point is that they would try to do it by SMART PA to where it doesn't actually have a hard stop. Dr. Todd: Right. So it would just be seamless, and nobody would know that we had PA on it. It just pings at the pharmacy because all the checkboxes have been check electronically. Dr. Ellermeier: If it's not electronic like at point of sale, then it would hard stop and they'd have to fill out a form with the patient's diagnosis. Dr. Larson: One question on it, would there be a way to exclude these particular drugs if the prescription was written by a neurologist, from basically the edit? Then you would have it where it would meet that because the prescription from the neurologist wouldn't be included in the bucket. Dr. Adma: So here is the scenario I'm concerned about: Lithium, Depakote, I write it. He goes to the neurologist and he writes Lamictal and then it would not hit the pre authorization for the neurologist, because he's a neurologist through the SMART edit. Then the next month, the patient comes to me and I write the Depakote and the Lithium, then I, for me, I'll hit the PA and then I'll have to fill out the form.	

	Dr. Larson: It wouldn't because it's not 3 different drugs. Are you saying you changed the drugs the second month? Dr. Adma: No, I'm not changing. I thought the neurologist won't hit it, but if I am prescribing two and they're prescribing one. Dr. Smith: I have just kind of a more basic question. What is the, just from a safety concern standpoint, when you hit 3 of these, we're just kind of discussing, when is there concern? Dr. Adma: The only concern I have is if they have a seizure disorder. Then the question is if these 3 are prescribed and they have seizure disorder and if any one of those are stopped because of the PA. Dr. Smith: But, should, I guess my question is more fundamental, should we even put PA on this at all? Dr. Porter: You know, there's an interaction between some of these medicines. Depakote, Lamictal, change the way it's titrated. The inducers, these are things that are part of our training. To take into account and I don't know. Great question, what would happen if you had three of these things together? What are we worried about here? Dr. Smith: What are we trying to prevent? Dr. Porter: If you, you could have some of them affect the level of the other one. Dr. Shoyinka: Stevens-Johnson syndrome. Dr. Smith: So, should this be a different criteria then, I guess is what I'm saying. Instead of three concurrent, should it be more of stop if you've got Lamictal and another agent that could cause Stevens-Johnson? Dr. Adma: No, we can't do that. I think clinicians understand how they interact when they prescribe. Dr. Porter: That's tough. That's a tough one. Cause there's also, just to make it slightly more complicated, there's quite a few seizure medicines that aren't on here. And some of which is used	

	off, even further off label, Trileptal is a non-indicated one, but it's on here but some people use Caprin and other things, it gets to be a little bit complicated. Gabapentin; there's a lot of things. I know we're towards the hard stop of this meeting. I think we probably need to think about the goal of this is and what it should include. Dr. Esslinger: Another way to look at it, too, is if unlike CDA typicals, where I think there's more concern than perhaps this one about improper use; given the low volume that we have here, and if you're saying you don't think most of the time it's an improper use, getting to Jonalan's point, should we not have a PA for this? Dr. Todd: Exactly. Dr. Adma: I think I would lean towards that. Dep. Sec. Dunkle: We'll put it on for a quick look again next time, just in, if anybody has come up with a reason why we need it between now and then. Dr. Porter: Say to the DUR, that we reviewed this and it's a very low number, we don't see a safety risk. Dep. Sec. Dunkle: If we don't see a safety risk then we're not going to forward anything. It just becomes, 'Yea, we reviewed it. There was a decision not to do anything about it.' Good to go. Dr. Smith: Is there a safety concern, I guess, from a take away standpoint, of mood stabilizers in which you guys do see an opportunity for improper use of mood stabilizers in some scenario? Maybe not concurrent use of them, but is it mood stabilizers plus something else that is of concern? Dr. Porter: There's just drug interactions that will effect. Particularly the Carbamazepine, to a lesser degree will lessen the effectiveness. It's not a safety thing really, not a toxicity thing, they'll just lower the effectiveness of other drugs. I see clinicians that are unaware of that and thus under dosing their atypical. It's not really a safety thing. Dr. Shoyinka: To your point, I know they're PA requirements in other states that's typically for women of child bearing age that have Carbamazepine and all contraceptive pills, there's an alert there sent to the providers and prescribers.	

	Dr. Smith: It's not a hard PA, though. Dr. Shoyinka: It's not a hard PA. Dr. Porter: Along those lines the thing that is probably the un-safest practice, in my personal opinion, obviously there are other people here, I do not think Depakote, with all the options in child bearing age women, is generally a great idea. The rate of unplanned pregnancy is extremely high in the non-bipolar population. So, I doubt if I've done a study in that population. And that's a really bad medicine for fetal development, buy the time you know you're pregnant the neuro tube's already done what it's going to do. That would be my safety concern. If we were going to do something, it would be something about that. Dr. Adma: I agree. Dr. Shoyinka: Good point. Same with Lithium. Dr. Porter: Lithium and Tegretol they're category D. They're all category D, but Depakote, to me, the one that's the dangerous one. Dep. Sec. Dunkle: What we'll do, since it is a pretty low number, and have Liane pull who it is that is prescribing the ones that would fall on that edit and we can look at it real quick. Like I said, unless somebody has determined a need between now and then to bring that one up or unless we need to do adjustments to it, then we can have those conversations.	
III. New Business A. Prior Authorization Criteria 3. Antipsychotic Dosing Limits for Children– Review proposed antipsychotic dosing limits for children.	**Clinical Public Comment: -** No requests were received. **Board Discussion:** Dep. Sec. Dunkle: What I'll suggest on the *Antipsychotic Dosing Limits in Children less than ___ years of age,* is that we go ahead and wrap this into that conversation about putting in something like the Texas matrix. Dr. Millhuff: Yes.	The criteria were tabled until the next MHMAC meeting.

	Dep. Sec. Dunkle: And bring that back to the next conversation and have that be a major agenda item. Dr. Millhuff: Great. I'd encourage those of the group to look at the numbers they had in this handout I gave you.	
IV. Process Improvement Initiatives C. DUR approved criteria timeline	**Board Discussion:** {This item was not mentioned}	For informational purposes only.
V. Open Public Comment*	**Public Comment: -** No requests were mentioned **Board Discussion:** Dr. Porter: I'd like to formally thank Chip for all the work he's put in. doing background research outside of the group. Thank you for this and everything you did. Dr. Adma: One more thing, Liane, as you're looking at Fanapt, what they say is once you over 6mg twice a day dosing, then before you go any higher than that, you need to get a genetic testing done. Did you do any genetic testing? Dr. Porter: I just starting to do it, but I didn't know of this particular topic you're bringing up. Dr. Adma: You might want to look more into it. Because I don't think a lot of people understand it and they just put it up to 24 and if you look at the package insert, they specifically talk about genetic testing. Dr. Porter: Boy, that's going to be a topic for this panel, especially when the next round of things comes to us. Dep. Sec. Dunkle: I'd like to thank everybody just for being here for the number of hours we have, and really getting through all the classification of drugs, at least the first round by July 1, which is, again, was kind of our charge by the legislature. So now I think we can transition to some different types of conversations, around things like the training, outreach, and some of those pieces. Of course, the criteria will still continue to be some of the more heady, take away work. But I think	

	that, we'll a little bit of additional time to have some conversations around some of these other suggestions and things we might consider especially to help with the prescribing practices among these drug classes.	
VI. Adjourn	Dep. Sec. Dunkle: Thank you all and unless anybody else from the committee has any comments we'll go ahead and adjourn. Seeing none. Alright, thank you.	Dep. Sec. Dunkle adjourned the meeting at 4:33pm.
*Clinical and open public comment requests and written testimony must be submitted one week prior to meeting to llarson@kdheks.gov. If providing clinical comment, please indicate which agenda item you are requesting time to comment. Time limits during period of comment will be determined based on number of requests received. The next MHMAC meeting is scheduled for August 9, 2016.		